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ABSTRACT

The purpose of this model curriculum and teaching guide is to assist agencies, educational institutions, and other groups to plan, organize, and provide the initial training needed by homemaker-home health aides. Persons aged 35-60 are considered most desirable as trainees, but indication of maturity is more appropriate as a criterion. Based on approximately sixty hours of classroom and laboratory instruction and fifteen hours of field practice, the curriculum contains these five sections, each with several units: (1) The Homemaker-Home Health Aide Service (5 units), a general orientation; (2) Working with People (8 units); (3) Practical Knowledge and Skills in Home Management (3 units); (4) Practical Knowledge and Skills in Personal Care (9 units); and (5) Application of Knowledge and Skills--The Practicum, a situation in the home with supervised guidance. Each unit includes some or all of the following: estimated time, suggestions to instructor, introduction to material, expected outcome, materials and equipment, content, teaching aids (exercises, exhibits, handouts, discussion questions), and assessment instrument. Appendix 1 contains four modules suggesting training content with added knowledge and skills in these areas: cancer, diseases of the circulatory system, developmental disabilities, and mental illness. They may be used for basic training, inservice or special additional training. Other appendixes include sample practicum material. (YLB)

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A MODEL CURRICULUM AND TEACHING GUIDE
FOR THE
INSTRUCTION OF THE HOMEMAKER-HOME HEALTH AIDE

CE 018 791

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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On May 4, 1980, the Department of Health, Education, and Welfare (DHEW) was reorganized. The health and welfare components became the new Department of Health and Human Services (DHHS). Any references to DHEW within this text should be considered as DHHS.

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FOREWORD

The homemaker-home health aide is a team member with professional health and social staff members who are responsible for providing home care services. These services are needed by the elderly, families with children, the chronically-ill and convalescent, and the handicapped. The homemaker-home health aide undertakes tasks in and demonstrates the care of the home and family, sound hygiene and nutrition practices, disease prevention and good health practices. These tasks are carried out based on an understanding of human needs and using learned knowledge and skills.

The purpose of *A Model Curriculum and Teaching Guide for the Instruction of the Homemaker-Home Health Aide* is to assist agencies, educational institutions and other groups to plan, organize and provide the initial training needed by homemaker-home health aides. This training will equip them to work in an agency under professional supervision and under a plan of care. It contains a generic body of knowledge necessary to provide homemaker-home health aide service, including home management, personal care, child care and the teaching aspect of the service.

The *Model Curriculum and Teaching Guide* was developed with the guidance of an Advisory Committee. This included representatives of agencies providing homemaker-home health aide services, organizations and federal agencies with experience and expertise in homemaker-home health aide services and a concern for the continuing development of quality care provided by qualified, well-trained personnel.

A Draft of the *Model Curriculum and Teaching Guide* was used by 22 Community Health Service, Department of Health, Education and Welfare grantees in some 80 training programs for homemaker-home health aides. A systematic collection of information from the users of the *Model Curriculum* was obtained and, based on these reactions, revisions have been made to strengthen and clarify areas of content. The *Model Curriculum and Teaching Guide* benefited greatly by a year's use and the thoughtful suggestions and reports submitted by these programs.

On the basis of widely recognized and accepted common tasks and training needs, the Advisory Committee recommends that *A Model Curriculum and Teaching Guide* be accepted as a minimum standard of of training for those providing supportive health and social services in homes, irrespective of funding source. The recommendation defines, in effect, a broad generic body of knowledge needed by the paraprofessionals who provide supportive health and social services in the home.

In recognition of the present-day trends, regulations and cost containment programs, including those that result in earlier discharge of patients from health care institutions, the Advisory Committee emphasized that the agency employing the homemaker - home health aides must provide or assure professional supervision as part of its responsibility for the delivery of quality services. It must assure also that ongoing in-service education be available to each homemaker-home health aide to maintain and improve his or her knowledge and skills.

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USE OF THE MODEL CURRICULUM AND TEACHING GUIDES FOR THE INSTRUCTION OF HOMEMAKER-HOME HEALTH AIDES

The purpose of the model curriculum and teaching guide is to assist agencies, educational institutions and other groups to plan, organize and provide the initial training needed by homemaker-home health aides. This curriculum will equip them to work for an agency and under professional supervision. It contains a generic body of knowledge considered necessary to provide a general range of homemaker-home health aide services, including household management, personal care, working with older people, child care and the teaching aspect of the service. Therefore, it will prepare the trainee to work in an agency that makes such a program or any aspect of it available.

This curriculum is based on the belief that each homemaker-home health aide needs and will obtain in-service training on a continuing basis. In addition, agencies may encourage some workers to specialize in one or more of the content areas. To facilitate this possibility, several modules suggesting training content with added knowledge and skills are included as appendices. Some agencies may wish to include these modules as part of the basic training; others will use them for in-service or for special additional training. In any event, agencies will need to make additional information available to the homemaker-home health aides, either directly or indirectly as they continue their work in the field.

The planning, organizing, selection of instructors and the use of content and teaching aids will be discussed in this Chapter.

Advisory Committee or Planning Group

It is believed that the training program can be enriched and designed to better meet the needs of a specific agency and/or the community if an Advisory Committee or planning group is appointed to help plan and organize the training program. Some communities may have an established advisory group or committee that would serve in this capacity. Some agencies have a person or committee responsible for training. Existing committees may be used if training is part of their function.

The purpose and role of the Advisory Committee or planning group may vary depending on where and by whom the training is to be conducted. If the training takes place in the agency, a committee of staff members and community agency representatives not only helps define needs and participates in training, but also becomes more knowledgeable and understanding of the capability and limitations of the homemaker-home health aides. This is particularly helpful for those involved in case management and/or in supervision of the homemaker-home health aides.

If the training is to be conducted as a joint activity with the American Red Cross, or other outside group, or by an educational institution, an advisory committee is a necessity for determining the philosophy and content of the program and to ensure that the needs of the consumer, community, agency and trainee are met.

The membership of the community-wide advisory committee should include representatives of the agencies employing homemaker-home health aides and any potential employers plus the educational institutions, e.g., community colleges and vocational schools, which may be doing the training, the American Red Cross, and experienced homemaker-home health aides. It will be helpful to include representatives of special community organizations, for example, health and social service groups, because of their knowledge of the needs and resources relating to special health and social conditions, e.g., cancer, heart disease, child abuse. When planning includes representatives of health, social and educational agencies, the results are more likely to be a balanced and integrated program. In addition, these planning groups will become interpreters of the program in the community. While the Model Curriculum provides for a generic body of knowledge and skills, a community or agency may wish to expand certain sections to better meet their specific requirements.

The Advisory Committee also has an important role to play in evaluating the effectiveness of the training activity in terms of:

- Employee satisfaction
- Agency satisfaction with the ability of homemaker-home health aides to function satisfactorily in the provision of services
- Meeting program needs of the agency.

Training Cost

A well-planned training program costs money. A budget should be developed to cover such items as rental of space, teaching aids and materials. Although the costs of films, literature and teaching aids may not involve a large expenditure, failure to plan for such expenses may become a deterrent to the program of instruction. There may also be costs involved in securing the needed teaching staff. Generally, most of the multidisciplinary staff are available from governmental agencies or are on the staff of community agencies. However, it must be remembered that the time of special instructors costs money. The cost of field practice must be considered and planned for. This should include the salary of the instructor and possible reimbursement of the agency when trainees are not employees of the agency. Plans to meet such costs may involve the need for contributions in money and personnel. An advisory group may be able to make useful suggestions about where and how to secure qualified faculty or funds from organizations. The cost of the training program, including in-kind contributions, should be computed and made known to the community.

Coordinator Responsibility

The success of the training program and the satisfaction of the homemaker-home health aides will depend upon the quality of instruction as well as a carefully planned and coordinated course. Therefore, the selection of the coordinator, who will have overall responsibility for the course, may be a primary factor in its success. Preferably, the coordinator should be knowledgeable about the homemaker-home health aide role and the services. Preparation, training or experience in teaching adults, such as mother and baby care classes, or community group work would be desirable. The title of the person with overall responsibility may differ, but responsibilities generally should be as follows:

- Work with the administratively responsible person in the school or agency

- Assume administrative responsibility for the training course

- Work with an advisory committee or with the training committee of the agency to insure that the program requirements of the agency and the educational needs of the homemaker-home health aides are met

- For teaching such classes and supervising field practice as is appropriate to the discipline and background of the coordinator

- Arrange for the various professional specialists as instructors. Since the homemaker-home health aide provides supportive health and social services for individuals and families, a variety of professional instructors should be involved, including nurses, social workers, home economists, physical therapists and field instructors from agencies. Persons serving as instructional staff should be experienced in the provision of homemaker-home health aide services or carefully oriented to the role and work of the homemaker-home health aide and the level and kind of content needed; experience in teaching adults would be helpful

- Conduct meeting(s) with the instructors to coordinate and integrate curriculum content, discuss the sequence of materials to be included, the expected outcomes of teaching, and the availability and use of resources, e.g., classrooms, laboratories, films, and equipment. The educational level and expectations of the trainees should be shared during meetings of the instructors. The meeting affords an opportunity to review adult education concepts as related to the trainees and as used in the development of the curriculum and teaching guide

- Assure that principles of adult education are being employed by instructors

- Attend class sessions to insure coordination and integration of curriculum content and ongoing assessment of trainee progress

- Know the trainees and be available for individual consultation

- Be responsible for the evaluation of the training program as follows:

    - Effectiveness of content and program in meeting the objectives as defined by the planning group

    - Effectiveness of teaching materials and techniques

    - Trainee reaction to both content and method of instruction

    - Success of trainees in developing knowledge and skills

- The evaluation may be based on:

    - Assessments of class sessions when applicable

    - Self-appraisal by trainees of their own progress; this helps the trainee to measure his or her own growth

    - Conferences with trainees and instructors

    - Evidence of ability to perform tasks by demonstration

- Formal methods:

    - Tests prepared by the instructors may be used. These should be simple statements carefully adapted to the educational level of the trainees.

Application of the Curriculum

The model curriculum is a generic body of knowledge which is presented in five sections. Each section has several units. The material is arranged progressively beginning with an orientation section that is intended to help the trainee begin to relate to the role of the homemaker-home health aide. After the general orientation, comes a section on working with people beginning with basic human needs. The Sections III and IV are concerned with the practical knowledge and skills in working with people to provide home management and personal care. The practicum, Section V, gives the trainee an opportunity to integrate and apply the learning that has taken place in the home situation under supervised guidance.

The curriculum is based on approximately 60 hours of classroom and laboratory instruction and 15 hours of field practice for a total of 75 hours. An "estimated time to complete" has been assigned to each unit. Although hours are indicated, these may need to be adjusted upward to the time needed to complete the unit and for the trainees to achieve the desired "outcomes." They may be more hours of training than are at present being provided in some agencies and communities and less than in other places. Where more hours are required, the section and/or a unit may be expanded to give more depth and breadth.

Each unit has an introductory statement that describes what is to be taught and its relationship to the knowledge and skills needed by the homemaker-home health aide. The objective is to provide the instructor with an understanding of the level of knowledge and skill that is applicable to the role and function of the homemaker-home health aide. Suggestions to the instructor are in script and include references to Exercises," "Exhibits," "Handouts," and "Discussion Questions" at the end of the unit.

The introduction is followed by a statement of outcome in learned knowledge and skills to be accomplished by the trainee. This provides the trainee with a measurement of progress and accomplishment in relation to each unit and should be reviewed with them. All the "outcomes" are stated in terms of what the learner ought to be able to do. Therefore, the content, class and laboratory experience should be directed so that the trainee achieves the expected outcome. If agency policy and program indicate a need to expand the content, it may be necessary to develop, ideally with the trainee's participation, the added expected outcomes -- within the basic purpose or the unit. The outcomes or goals should always be in terms of knowledge gained or performance of skills. The content is described for instructors' guidance. Local programs and policies may require additions. Most units include an assessment instrument. This may be used orally or written, as preferred. If the trainees worry about written assessment, the "discussion questions" might be used instead. The assessment instrument(s) may also be used as a pre-test tool if the instructor so desires.

The Model Curriculum requires a practicum -- supervised field practice. When the training is conducted by a group or by an educational institution, it is essential that agencies participate in planning for and providing facilities for this learning experience. Experience in using the Model Curriculum has demonstrated that the use of a committee representing agencies and the training program resulted in the most satisfying and effective field practice experience. The committee established objectives and helped facilitate the field practice (see Appendix III). Equally important to the success of the field practice is an agreement between the training program (community college or other source) and the agency(ies) providing the practice. It should specify who will instruct and supervise the practice and the role of the instructor from the training program. (See Appendix IV.) Providing field practice may be a valuable recruitment source for agencies by giving an opportunity to observe the aptitude and ability of the trainee.

When field practice takes place in the employing agency, there is more latitude in providing the supervised field practice. Experience can take place when specific opportunities present themselves. This is particularly true when the trainee works part-time and attends classes part-time. However, it is necessary that a person within the agency be responsible for coordinating and assuring a varied field experience. (Appendix V, Example of Documentation of Field Practice.) The employing agency has an opportunity to participate in the instruction of its employees.

Patterns of Training

The model curriculum and teaching guide is adaptable to the pattern of training selected by the agency or advisory committee. One desirable and educationally effective method is a learner-work plan in which the trainee spends part of the day in class and part of the day working. It provides the agency with a part-time employee and allows the trainee to earn while being trained. An alternate method might involve two days in class and three days working. This is not as desirable because trainees appear to do better when classes are limited to three or four hours a day. Some successful training programs plan for a period of class instruction followed by a period of field experience in the agency, followed in turn by another period of instruction. In some instances, it may be more practical to conduct the training in a continuous program and follow it with field practice.

The use of the curriculum and teaching guide may vary according to the training plan adopted by the agency or the group providing training. If training is to be accomplished primarily outside the agency, then a pre-orientation period in the employing agency should be a prerequisite.

The content of each section and unit is considered basic and essential for the homemaker-home health aide, with emphasis being placed on the ability to perform tasks or demonstrate acquired skills and knowledge. The sections and units are arranged for the orderly development of knowledge and skills. However, it may be necessary to alter the order of the units in relation to the number of trainees. A recent study indicated that half of the agencies have five or less homemaker-home health aides. It would be possible to use units on a individual basis.

The number of trainees should be based on availability of space and arrangements for demonstrations, laboratory activities and field practice. It is prefereable to limit classes to three or four hours a day. Adults are not accustomed to sitting for long periods. In some instances, this limited number of hours per day may not be practical. Field observations and laboratory practice could take up part of the day. Plans should be made to complete the training within a definite time period. It is more satisfying to the trainee if the actual length of training is known.

The practicum (supervised field practice) may be arranged for a specific time period if the training takes place outside the agency. If a learn-work plan is in effect, the supervised field practice may be incorporated as the trainee is ready for the experience. It should be for a minimum of 15 hours.

The add-on modules referred to earlier have been developed for use by agencies and training programs that wish to include indepth knowledge, either as part of the basic course, or as part of the in-service training program. If an agency provides services for families having individuals with developmental disabilities or mental illness, for example, these units will provide a greater depth of knowledge and skill needed by the homemaker-home health aide. The best use of these modules, however, is for the additional training of the experienced homemaker-home health aide.

Teaching Aids

The teaching aids follow each unit and are on colored paper. These are intended to facilitate the work of the coordinator and instructors in planning and gearing up to achieve the specific learning "outcomes," but should be used at the instructors' discretion. The aids generally consist of:

- Exercises that provide situations for problem-solving and discussion which may be used to help the trainee focus on and better understand the role of the homemaker-home health aide in given situations relating to most of the units

- Exhibits are furnished to highlight aspects of certain units. These may be used for transparencies

- Discussion questions may be used as an "oral" approach to ascertain the learning that has taken place or as a means of emphasis

- Handouts are provided for reproduction and distribution to the trainees and generally relate to details of content; trainees should be encouraged to put these in a binder
- Some popular-type pamphlets are also suggested for purchase and handout
- Some visual aids are listed in the Selected References at the end of each unit.

Trainee Selection

The selection of trainees for homemaker-home health aide services may or may not be the responsibility of the training program. Employed homemaker-home health aides or prospective employees will be selected by the agency according to its own criteria and qualifications for employment. Community colleges prefer to conduct courses for already-employed homemaker-home health aides or to meet demand for a certain kind of worker. However, when community colleges or employment agencies counsel prospective homemaker-home health aides, it is important that they be knowledgeable about the work to be performed by the homemaker-home health aide. Any attitude to the effect that homemaker-home health aide services are something which "anyone can do" should not go unchallenged. It should be emphasized that, whereas preparing a meal or shopping may seem routine, it is different when done in a home other than one's own and especially where the individual or family being served is undergoing a crisis. When chronic illness is present, there are many problems demanding the knowledge and skills of the homemaker-home health aide. For example, preparing a meal may be complicated by a prescribed modified diet, lack of appetite, likes, dislikes and cultural differences. Also, the effective use of medications may be affected by certain food intake.

Over the years a number of articles have been written by persons experienced in homemaker-home health aide services in an effort to describe the "ideal" recruit. They all indicate that there is no ideal. All the articles consider certain personal qualifications essential -- being able to get along with people from a variety of backgrounds, reliability, being a supportive person, and so on. Therefore, personal interviews are an essential procedure for selecting the prospective homemaker-home health aide. The ability to utilize the initial training, supervision, and an ongoing in-service training program are also important qualities in the potential homemaker-home health aide.

The person or persons conducting the interview should determine if the trainee exhibits certain characteristics, including the following:

Maturity: Although persons between the ages of 35 and 60 have been considered most desirable, there is no age limit. Maturity should not be associated with age, but rather with a demonstration of certain characteristics -- independence, self-direction and self-discipline.

Concern: A genuine concern for people, with a tolerance for their differences and points of view.

Sensitivity: The ability to observe can be achieved through training but is enhanced by the person with an innate sensitivity to people and conditions.

Learning ability: The homemaker-home health aide must be able to acquire the knowledge and skills needed to care for the ill and disabled, children, and the elderly in their homes. Evaluation of learning ability should not necessarily be related to the grade completed in school.

Communication: The homemaker-home health aide should be able to express herself well enough to communicate effectively with family and agency staff. It is also necessary that the homemaker-home health aide be able to keep adequate written records of her activities and observations.

Health: The homemaker-home health aide must be physically able to cope with the demands of the job, such as standing, walking, lifting, stretching, cleaning.

A grasp of what is involved in this kind of work and the attitudes of the homemaker-home health aide to it, can usually be established during the interview.

A warm, outgoing personality is a major criterion in the selection of the homemaker-home health aide as a basis for relating to individuals, families, and children. However, there is a need for enough detachment to allow for objectivity in working with people.

The Homemaker-Home Health Aide Trainee

The model curriculum and teaching guide is based on concepts of adult education and the processes by which adults learn best. The adult homemaker-home health aide trainees bring to the training experience crucial characteristics, such as maturity and a life's experience. They also have a readiness to learn and interest in applying the new skills and knowledge. These determine how the training should be designed and implemented, and indicate use of methods that differ from those associated with the teaching of children.

Usually mature individuals are recruited for homemaker-home health aide services. They have developed personalities, are independent and accustomed to being self-directing in their activities and to making their own decisions. Their responses to the educational experience will be influenced by their individuality and expectations. With an increasing number of courses being offered by community colleges and technical schools, some participants may be younger. Even so, the level of maturity is a basic consideration in the selection of homemaker-home health aides. They usually have had experience rearing their own or someone else's children.

As assessment of past experience is necessary to establish a relationship between the trainees' need for instruction, the role of the homemaker-home health aide, and the goals of the agency. When the problem-solving method is used, the previous experience of the trainee becomes a resource and a frame of reference that can enrich the learning experience and make it more meaningful.

Learning for the homemaker-home health aide is designed for immediate use, either in the work situation or in an anticipated one. The model curriculum and training guide has been developed to emphasize learning by doing, practicing and problem-solving. In addition, the trainee should be constantly aware of progress made in mastering knowledge and skills. Results of much of the learning can then be measured by observable criteria based on the expected outcomes of training. Although expected outcomes have been suggested, the trainee and instructor may define these jointly. If a learn-work plan is used, the homemaker-home health aide may be able to define a problem for which skills are needed in terms of a given unit. Trainee participation is desirable as long as the basic knowledge and skills are covered.

If the trainee is to be actively involved, lectures or information-giving should be limited. A certain amount of information must be provided as a basis for the trainee's active participation. Trainee knowledge and experience can be helpful in the discussion of subject matter. It is also important to break a subject or skill into small parts that can be mastered easily. Each unit includes a problem-solving situation or exercise that involves student participation.

Setting the climate for learning is especially important when working with adults. A comfortable, attractive physical setting is a must. Chairs and the room temperature must be comfortable, lighting adequate, with good acoustics. If possible, the location should be easily accessible, and parking should not pose a problem. Since many will not be accustomed to sitting for long periods, coffee and soda breaks are essential. This also permits opportunities for interpersonal interactions, which facilitate integration of the information and are basic to problem-solving discussions.

REFERENCES

Austin, Michael J. Professionals and Paraprofessionals. Human Service Press, New York: 1978, pp.93-134.

Engalls, John D. A Trainer's Guide to Andragogy. U.S. Government Printing Office, Washington, DC: pp.1-21.

National Council for Homemaker-Home Health Aide Services, Inc. Standards for Homemaker-Home Health Aide Services. 1965, pp.22-23. Readings in Homemaker Service. 1969, pp.116-119; pp.129-132. A Unit of Learning About Homemaker-Home Health Aide Services. 1968, pp.37-4_. Homemaker-Home Health Aide Training Manual. 1969, pp.10-13.

The following three references are obtainable at a nominal cost from the National Association for Public Continuing and Adult Education, 1206 - 16th Street, NW, Washington, DC 20036. It is suggested that the instructors may find these useful:

- A Treasury of Techniques for Teaching Adults. (1964), pp.10-14
- Tested Techniques for Teaching Adults. (1972)
- The Second Treasury of Techniques for Teaching Adults. (1970)

Trager, Brahna. Homemaker-Home Health Aide Services in the United States. DHEW, Pub.No.HSM 736407 - June 1973, pp.153-157.

SECTION I

THE HOMEMAKER-HOME HEALTH AIDE SERVICE

The first section is intended to engender in the trainee a feeling of pride in being a homemaker-home health aide, to develop an understanding of the service provided to individuals and families in the home, to understand the relationship with professional workers, and to become oriented to working in an agency as a part of a community service.

UNIT A: WHAT HOMEMAKER-HOME HEALTH AIDE SERVICE IS

ESTIMATED TIME: 1 hour

SUGGESTED INSTRUCTOR: The coordinator (instructor) of training for homemaker-home health aides should conduct this section. If the coordinator is not from a homemaker-home health aide agency, the executive director or supervisor of a homemaker-home health aide service should be asked to participate, especially when the training takes place in a community college or on a community-wide basis, such as courses conducted by the American Red Cross and others.

INTRODUCTION

This section is designed to give the trainee a sense of pride in being a homemaker-home health aide, and to generate a sense of belonging to an important helping profession that is national and international in its membership.

The first meeting period is a time during which acquaintances are made among trainees, and between them and the coordinator/instructor. It is a time when basic attitudes and feelings about the homemaker-home health aide role may well be formed. It is therefore important to emphasize at the outset the responsibility of the trainee to attend every class hour of the course. The anxiety of the trainee entering upon this new experience can be reduced if the coordinator/instructor introduces and discusses the use of the several modes of instruction that will be used in the course: informal discussion, demonstration, and the practice of skills and problem-solving methods.

The coordinator/instructor will know something about the trainees from their applications and from interviews. The participation of trainees in this first section will give a better understanding of them. The coordinator/instructor should be sensitive to those elements of background and experience that will influence their performance as future homemaker-home health aides. This added insight will allow the instructor to adapt the training program to each individual -- with the goal of equal competence among them all at the end of training, regardless of disparities in prior experience.

EXPECTED OUTCOME

The trainee will be able to:

- describe the various activities of a homemaker-home health aide
- describe what he or she can and cannot do; and what others can and cannot do, in the role of homemaker-home health aide
- list general skills and specific skills that this course will teach.

MATERIALS AND EQUIPMENT

- Projector and flip chart.

CONTENT

The instructor should spend a brief period on introductions and on setting up details of the course. Individuals should be given the chance to make each other's acquaintance. Baselines for operation of the course can then be set, i.e., schedules, hours, responsibilities, and the like.

The first activity the coordinator should introduce will involve trainees in thinking about and relating to the role of homemaker-home health aide, and the services provided.

Suggestions for this first activity might include:

- allowing a panel of experienced homemaker-home health aides to tell stories of typical individuals and families served, and what they did in each situation. Although the cases these aides use will have to be carefully selected, the aides giving the descriptions should be encouraged to use their own words
- using films like the National Council's "A Better Answer," or "Homefires," to stimulate discussion of the service. Slides or other audiovisual aids may be available locally that show what the homemaker-home health aide service does
- using case studies to describe services the homemaker-home health aide provides (*see exercises attached to Unit B*).

The coordinator may elect to explore with the trainees in which of these activities described would they feel most comfortable; in which of the situations described or shown would they feel most or least comfortable -- and explore the reasons for this feeling. This can lead to a discussion of the skills that the trainees themselves feel they have the greatest need to learn. Listing these (see Exercise 1, "Listing Learning Needs") may be a good basis for a general discussion of skills to be mastered.

AIDS

Exercise I: Listing Learning Needs

Exercise 1: Listing Learning Needs

This exercise may be used in Units A, B and C. The exercise is designed to provide the trainee an opportunity to learn about individuals and families and the kinds of health and social problems that need homemaker-home health aide services. The trainees should begin to relate to these in terms of the kind of knowledge and skills needed, where they feel comfortable in their present knowledge, and where they need additional training. It should not be expected that all needed knowledge and skills will be defined at this time.

This exercise can provide the instructor or coordinator with a sense of the strengths and entrance skill limitations of the trainee group and of individual trainees. The process will begin to provide a base for the training program, specify learning needs perceived by the trainees, and identify learning resources within the group.

- The panel discussion or visual aids should establish work situations to which the trainees will be able to relate because of caring for their own families and homes or from previous work situations. Discussion might include:
  - Which of the homemaker-home health aide tasks observed have they performed at some time?
  - Have they performed these tasks or activities in a home other than their own? How was this different?
  - Which tasks would the trainees individually or as a group be comfortable in doing? List these on a flip chart. Try to involve all the trainees.
  - In which homemaker-home health aide tasks and activities do the trainees think they need more knowledge and skill?
- List training needs on the flip chart.
- Compare learning needs with areas of comfort, and have trainees identify similar items from other experiences. Some will be experienced in a task; others will not.
- Review the list, making reference to specific parts of the training program to show when and generally in what way each of the items will be addressed. For example, if an item relates to personal care, the instructor could indicate that it would be discussed next week, giving the training unit title, and that there would probably be a field experience for practice of the skill.
- Indicate that the list would be used in a later session.

UNIT B: THE ROLE OF THE HOMEMAKER-HOME HEALTH AIDE

ESTIMATED TIME: 1 hour

SUGGESTED INSTRUCTOR: Supervisor from a homemaker-home health aide service, social worker or community nurse

INTRODUCTION

Unit A provided the trainee with a general understanding of the homemaker-home health aide role. In Unit B, these will be defined more sharply within the context of social and health support services and the role in the care team.

EXPECTED OUTCOME

The trainee will be able to:

- describe meaningfully how the role of the homemaker-home health aide meshes with the rest of the home care team, and the special responsibilities of the homemaker-home health aide in that team

- describe briefly those features and changes in home and family life to which the homemaker-home health aide should be alert

- describe the tasks of the homemaker-home health aide in a variety of home care situations

- define the qualities of a successful homemaker-home health aide

MATERIALS/EQUIPMENT

Sheets containing case stories will be handed out.

CONTENT

Part I: The Care Team

The concept of teamwork and the ways in which the homemaker-home *health aide fits in with the work of a team will be explored in this part.*

The homemaker-home health aide and one or two professionals comprise the primary helping team in providing care. But a variety of professionals, ranging from physician or psychiatrist through various therapists, nutritionists, and others, may at times be members of the team. Depending on the plan of care worked out by the agency providing service, the professionals may be drawn into the home situation to work on special difficulties. Some of these difficulties may have been identified by the observant homemaker-home health aide. Other professionals may be brought in from the primary agency's own staff, or from other agencies. *(See Handout 1, Professional Persons With Whom the Homemaker-Home Health Aide May Work.)*

The following case history illustrates how other professional persons may become involved:

> In one of their regular weekly conferences, a homemaker-home health aide and a social worker shared their common concern about eight-year-old Betsy M. The homemaker-home health aide reported that she had not been successful in persuading Mrs. M. to take any of her children to a clinic for a medical checkup. The reasons given by the homemaker-home health aide to persuade Mrs. M. to do so led the social worker to think that Betsy might be a diabetic. The social worker therefore made an appointment right away to talk to Mrs. M. in an attempt to persuade her that Betsy must be taken to see a doctor. It turned out that the suspicions of the homemaker-home health aide and the social worker were right. Betsy was indeed a diabetic. A public health nurse instructed Mrs. M. in the procedure for administering prescribed medication and in taking the frequent urine samples that are required when a diabetic is as young as Betsy. A nutritionist helped Mrs. M. understand that Betsy's diet had to be carefully supervised as the physician prescribed. She helped both Mrs. M. and the homemaker-home health aide to plan meals that would be good for Betsy, and still would be meals the whole family would enjoy. The social worker, the public health nurse and the homemaker-home health aide all worked together in teaching Mrs. M. how to manage Betsy's health and emotional needs without, at the same time, setting her apart from her brothers and sisters.[1]

In this case history, the social worker and the homemaker-home health aide were the primary care team. They were joined as the need arose by a public health nurse, a physician from the clinic and a nutritionist. *(Refer to Exhibit 1.)*

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[1] Widening Horizons - The Teaching Aspect of Homemaker Service. National Council for Homemaker-Home Health Aide Services, Inc., New York, NY: 1974, pp.41-42.

The members of a primary care team are complementary. That is, their educational background, areas of competence and service experience interlock and are interdependent; each needs the other. The homemaker-home health aide is a significant component of the team because of the frequent and consistent contact with the individual and family. In many instances, the homemaker-home health aide is the primary person concerned with implementing and maintaining the treatment plan, using specially learned skills to provide day-to-day help, to support, demonstrate, and teach in the home.

The education and training of the professional person includes a body of specific knowledge which, supplemented by experience, allows skillful application in solving a specific individual or family problem. There are two ways that the professional's skill is applied: it is focused on the specific problem of the individual or family served, and it is used to support and guide the homemaker-home health aide.

Part 2: The Homemaker-Home Health Aide and the Individual and Families

Next, we turn our attention to the responsibilities of the homemaker-home health aide to the individual and the family.

Each member of the service team has specific responsibilities to the other team members and to the family or individual being served. The homemaker-home health aide working with the individual and family served takes into account the following:

- the care or assistance the professionals have determined is needed

- carrying out tasks that insure maintenance of a good quality of family life (routine home management, house-cleaning, doing the laundry, ongoing personal care of children and adults)

- maintaining stability and order in the home by teaching individuals and family members how to improve their standards of nutrition, housekeeping, child care and self-care

- giving personal care specified by and supervised by appropriate health professionals, to support overall medical treatment or alleviate the discomforts of illness or disability

- to maintain the self-respect and dignity of the individual(s) or family that is being helped, to encourage these persons to make their own decisions, and to keep personal matters confidential.

Part 3: The Homemaker-Home Health Aide Working With The Care Team

The instructor may wish to use Exhibit 1 and Handout 1 in discussing work with the care team.

In all of the above, the homemaker-home health aide focuses on the individual and/or family that is being helped. There is another set of responsibilities -- relationships. These link the homemaker-home health aide with the professional members of the helping team. Among these are:

- willing to work as a member of the team, and to accept guidance when it is given
- growing in self-awareness, skills and knowledge which can be used to help others
- carrying out the plan of care developed by the professional members of the team
- remaining alert to the individual and family functioning so that one is aware of changes in physical, mental or emotional states that could influence carrying out the plan of care
- sharing observations of such changes with appropriate professionals
- maintaining work records that allow other team members to evaluate what has been done and what should be done, or changed, the better to help the individual or the family as a whole.

There is a wide diversity in the situations in which the homemaker-home health aide is likely to become involved, each of them requiring differing mixes of tasks and skills. In Exercises 1 through 6 a number of case studies are presented that will help in becoming acquainted with that diversity. The exercises can be used as case illustrations, or they may be used as a basis for role-playing exercises or to generate further discussion.

An attempt should be made to involve trainees in personal identification with the work of the homemaker-home health aide and in their possible relationships with families or with individuals or with other team members. In role-playing, especially, it may be valuable for an individual to take the place of the homemaker-home health aide in one scenario and to take the place of the person being served in another.

Whatever use is made of the case studies, the class should discuss the feelings of the homemaker-home health aide and the feelings of the person being served. This can lead to a description of what further skills the training program should seek to develop in the trainees that could allow them to operate effectively in each of the situations described by the cases. The skills identified can then be added to the list already compiled by the group as part of Unit A, Exercise 1.

Discussion of the exercises should include:

- *the concept of team relationship among the social worker, nurse and homemaker-home health aide, which implies mutual sharing and respect for each other's individual skills and judgment*
- *the idea that supervision is a shared responsibility, that a supervisor is available as a backstop in difficult situations, that the homemaker-home health aide brings insights and observations into play and is able to use judgment to advantage*
- *emphasis on the purpose of the service as a commitment which all members of the staff share*
- *the personal qualities, understanding and skills that a homemaker-home health aide should have in order to work effectively with persons from all walks of life, with varying cultures, backgrounds, beliefs and practices.*

AIDS

Exercise 1: Emmons Case Story

Exercise 2: Mason Case Story

Exercise 3: Waverly Case Story

Exercise 4: Brunetto Case Story

Exercise 5: Watson Case Story

Exercise 6: James Case Story

Exhibit 1: The Care Team

Exhibit 2: Responsibilities of the Homemaker-Home Health Aide

Handout 1: Some of the Professional Persons With Whom The Homemaker-Home Health Aide Will Work

Exercise 1: Emmons Case Story

This case, through role-play and discussion, brings out the feelings of the mother who feels herself supplanted and her worth diminished by the efficiency of the homemaker-home health aide. The homemaker-home health aide is eager to be of help but does not understand the effect she is having on the family relationships. It also describes typical tasks.

- Introduce the exercise

- Read or hand out the brief story:

  Mrs. Emmons, 27 years old, was hospitalized for a postpartum depression shortly after her second child was born. She left behind a dirty home, a frightened seven-year-old, the three-week-old baby and an anxious husband. A homemaker-home health aide about the same age as Mrs. Emmons was placed in the home. This was one of her first assignments, and she was eager to make a good impression. She performed many extra chores, and restored order, cleanliness and regularity in the household. Soon glowing reports came to Mrs. Emmons from her husband, about the homemaker-home health aide's skill and many achievements. Mrs. Emmons' depression increased, and she showed much apprehension.

- Role-play using a trainee in the role of Mrs. Emmons and another trainee as the homemaker-home health aide

- Discuss ways in which the situation could be avoided

- How might the homemaker-home health aide help Mrs. Emmons regain her feelings of self-worth? How might the homemaker-home health aide help Mr. Emmons to understand his wife's feelings about her role in the home? How would the homemaker-home health aide's role change when the mother returned home needing some assistance in resuming her role as wife and mother gradually?

Exercise 2: Mason Case Story

This role-playing situation should focus on the techniques the homemaker-home health aide might use to win confidence and friendship of testy, independent Mrs. Mason, and the ways that the homemaker-home health aide and supervisor can contribute to a sense of her independence and of her right to make her own decisions. Mrs. Mason's attitude toward the supervisor who came without calling first, and who apparently was patronizing, can be explored. The tasks and service needs can also be identified.

- Introduce the exercises

- Read or hand out the story:

  Mrs. Mason, at 95 years of age, could hear a loud voice only in her left ear. Her eyesight was dim and she was none too steady in walking, but she managed to get to her doctor's office unescorted. Her mind was extremely alert, and her independence and Victorian stoicism were sometimes a cause for concern. Resistance to accepting her increasing physical limitations was exhibited by condescending to carry her cane but not to use it. Upon her physician's advice, she accepted the visit from the visiting nurse, but treated her with reserved friendliness, as a somewhat "necessary" guest.

  Eventually, a homemaker-home health aide was successful in establishing a relationship with Mrs. Mason, called every day for a time, and stayed for half an hour to perform a specific chore. She then came on a half-day basis on weekdays only. The suggestion of a grab bar in her bathtub was rejected until the homemaker-home health aide persuaded her to look at one. Since it was not a permanent fixture, it was finally accepted. The homemaker-home health aide field supervisor was told, "One does not come to call uninvited, much less to treat me like a child."

- Assign roles for Mrs. Mason and the homemaker-home health aide, and role-play. Several different trainees can be involved or the roles reversed

- Discuss ways of gaining entrance to a home and maintaining an individual's independence.

Exercise 3: Waverly Case Story

This case describes a situation in which an amputee has lost pride and self-confidence. A plan of care is also identified.

- Introduce the story

- Read or hand out the story:

  Mr. Waverly, 64 years old, has has a below-the-knee amputation resulting from a circulatory disturbance. The amputation was a terrific blow to his pride and self-confidence. When he was discharged from the hospital to return to his trailer, where he lived alone, a referral to the Visiting Nurse Association was made with a request for homemaker-home health aide service. The idea was to encourage Mr. Waverly to do what he could for himself. The homemaker-home health aide was to encourage the use of the prosthesis (artificial leg) and to see that he ate three balanced meals a day. The hospital predicted that the nurse and the homemaker-home health aide would find Mr. Waverly in bed when they called, and they did.

  Daily service was planned at first, with gradual withdrawal as Mr. Waverly began to make progress in the use of the prosthesis. Mrs. Hamline, the homemaker-home health aide, was very sensitive to his needs, interceding when he needed her help and sensing when to have him do for himself. Mrs. Hamlin's daily schedule was reduced to three, then two, times each week. The visiting nurse continued to visit for a while after the homemaker-home health aide's services were terminated, and on her last visit Mr. Waverly announced that he had taken his car out and gone for a drive. His parting words were, "I'm so proud."

- Guide discussion or use selected role-plays.

Contrast the situation of Mr. Waverly with that of Mrs. Mason. What was the significance of finding Mr. Waverly in bed? Have the trainees suggest ways that Mr. Waverly could be encouraged to overcome his lowered self-esteem and his fear of or distaste for using the artificial leg. Discuss the wisdom of the plan to have intensive service at first and then a tapering off until Mr. Waverly had enough confidence to manage entirely on his own.

Exercise 4: Brunetto Case Story

This vignette can be used to explore the trainee's attitudes toward death and dying and toward being with someone who is dying. The instructor can point out that this subject will be handled in greater depth later in the course. *See Section II, Unit H.*

- Introduce the exercise

- Read or hand out the case story:

  Mrs. Brunetto, the homemaker-home health aide, reported that the mother, Mrs. Finazzo, suffering with a terminal illness, seems increasingly irritable and unhappy. The children, upon returning home from school, hang around the kitchen with Mrs. Brunetto and seem reluctant to spend any time in their mother's room. Mrs. Finazzo cries and yells at the children, accusing them of not wanting her any more. Then she demands unusual attention from Mrs. Brunetto just when she is preparing the evening meal. Mrs. Brunetto understands that Mrs. Finazzo is extremely fearful about her deteriorating health.

- Assign the roles

- Guide discussion.

Role-playing in this situation can include the feelings of the dying mother, the children and the homemaker-home health aide. It can also be used to make the point that the homemaker-home health aide should call upon the professional members of the team to help deal with the intense feelings and fears of the children and their mother.

Exercise 5: Watson Case Story

This case will give the trainee an opportunity to discuss how teaching by demonstration and carefully involving the mother in the care plan can be achieved and, at the same time, explore how the mother might react to these efforts to change her pattern of life. It also affords an opportunity to discuss discouragement when a plan that seemed to be succeeding suddenly shows severe slippage, and what the homemaker-home health aide's attitude might be when this happens.

- Introduce the exercise and its objectives to the trainee

- Read or hand out copies of the Watson story:

  Mrs. Watson, a 35-year-old widow, with seven children from two to 14 years of age, is receiving a public assistance grant for herself and her family. Due to her extremely poor physical and mental health, Mrs. Watson is attending a series of out-patient clinics, including group therapy sessions and individual treatment from a psychiatrist. A homemaker-home health aide was placed in the home to assist in child care and household management and to try to teach Mrs. Watson, to the extent possible, how to shop, how to plan for the family's needs within the assistance grant, and how to cope with the heavy responsibility of rearing seven children alone.

  The case record described the living conditions in the Watson home as "intolerable." Mrs. Watson was known to misuse her money on expensive toys and clothing for the children, which were quickly ruined for lack of proper care. Mrs. Watson complained that the assistance was inadequate to meet the family's needs.

  The homemaker-home health aide spent some time in pricing necessary articles and food in the neighborhood before accompanying Mrs. Watson on their first shopping expedition. She had listed, with the mother's help, the things which were most important to her in the way of food and clothing after careful inventory of the children's clothes and the food supplies on hand. Mrs. Watson was disinterested during the planning and counting sessions but enjoyed the shopping trips. She stayed within the plan with the homemaker-home health aide's help. Care of things purchased and appropriate use of them, however, was a different matter. The homemaker-home health aide became discouraged upon returning to the home several weeks later to find that Mrs. Watson had made additional purchases not within the plan and had returned some of the children's clothing and discarded a new article by using it as a floor mop.

- Discuss or assign roles for role-playing

Exercise 5 (continued)

- Discussion questions might include:

  How should the homemaker-home health aide approach the situation now? Should she reprimand Mrs. Watson? Show her own disappointment? Try again to reestablish the goals of the plan with Mrs. Watson? Discuss her own feelings with her supervisor?

Exercise 6: James Case Story

This case describes a situation in which a homemaker-home health aide is unjustly accused of stealing. It allows for exploration of how a homemaker-home health aide should respond to such a situation.

- Introduce the exercises
- Read or hand out copies of the story:

  Mrs. James, 82 years old, accused the homemaker-home health aide of stealing. The caseworker learned that the homemaker-home health aide had rearranged the pots and pans by putting the long-handled pans away, but Mrs. James had forgotten this. She suffered from organic brain syndrome, her hands trembled and her coordination was very poor. Consequently, it was unsafe for her to use certain articles around the stove. The caseworker and homemaker-home health aide attempted to reassure Mrs. James about this, but Mrs. James demanded the homemaker-home health aide's dismissal, even though the cooking utensils were brought out of hiding and the safety measure explained.

- Guide discussion.

Was there some way that this situation might have been avoided? What might the homemaker-home health aide have done differently? How will the homemaker-home health aide handle her own feelings about the unjust accusation? Should another homemaker-home health aide be assigned to Mrs. James? If this happens, will the homemaker-home health aide be able to rise above her feelings and continue to perform well on other assignments?

Exhibit 1: The Care Team

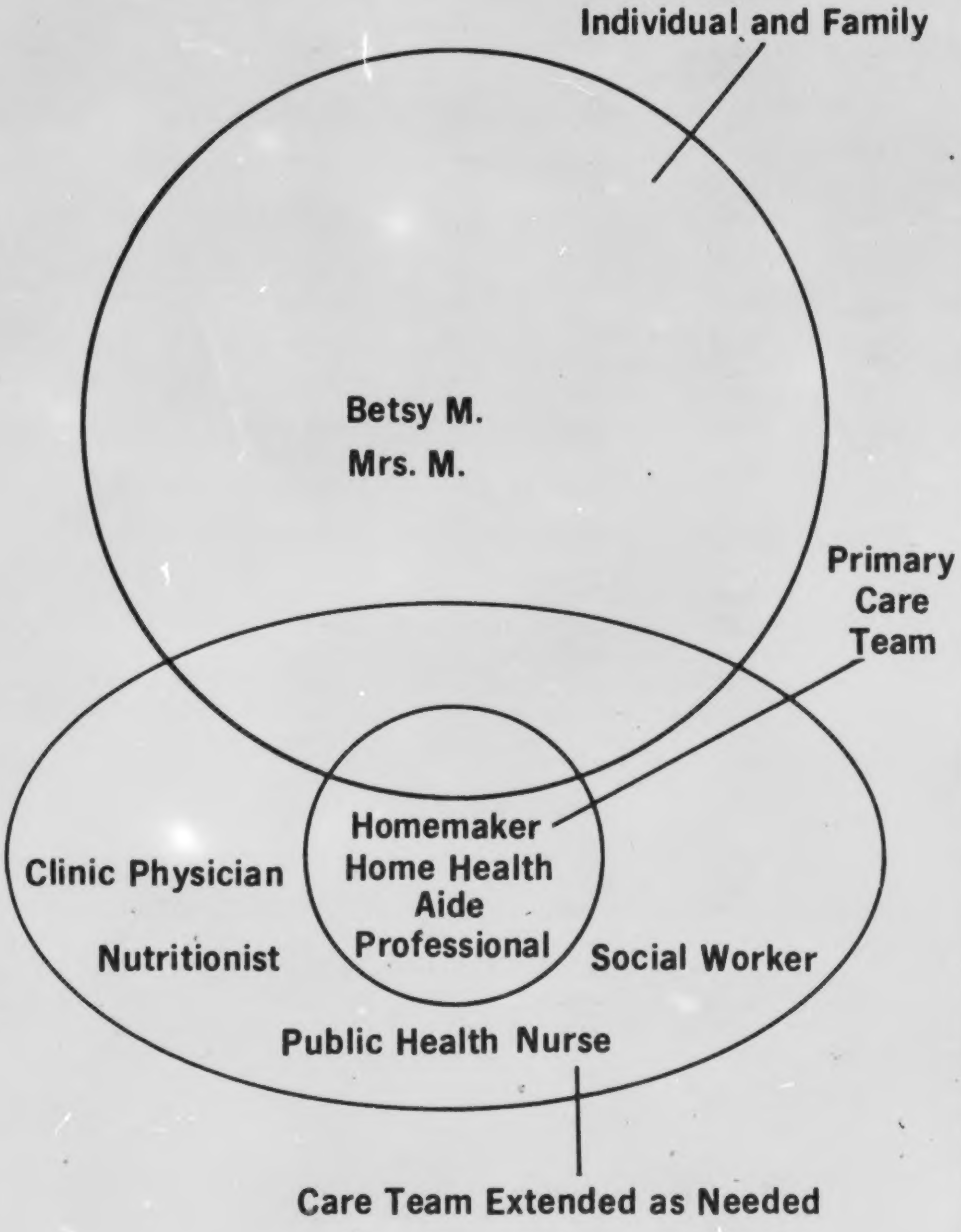
Individual and Family
Betsy M.
Mrs. M.
Primary Care Team
Homemaker
Home Health Aide
Professional
Clinic Physician
Nutritionist
Social Worker
Public Health Nurse
Care Team Extended as Needed

Exhibit 2: Responsibilities of the Homemaker-Home Health Aide

To The Family Or Person

- Be on time for assignment
- Perform essential home management tasks
- Provide support to individual and family
- Provide personal care
- Demonstrate respect and accept family's value systems
- Help family members to do for themselves

To The Team

- Participate as a member
- Share with team
- Work within plan of care
- Observe functioning
- Provide immediate feedback when necessary
- Maintain good records
- Continue to grow

Handout 1: Some Of The Professional Persons With Whom The Homemaker-Home Health Aide Will Work

Community Nurse (public health nurse) is an individual who has completed a baccalaureate program, and is able to integrate nursing practice and public health practice and apply it to the promotion and preservation of the health of the population. The nature of this practice is general and comprehensive, includes all ages and diagnostic groups and is non-episodic and continuous.[1] The community health nurse is a registered nurse, licensed by the state in which he or she is practicing.

Director or Administrator is a person who organizes and directs the ongoing functions and activities of an agency providing homemaker-home health aide services, either singly or in combination with other health or social services.

Nutritionist (public health nutritionist) is a professionally prepared person who applies the science of food consumption and utilzation to the growth, maintenance and repair of the human body.

Occupational Therapist is a person who is a graduate of an approved occupational therapy curriculum. Occupational therapy is concerned with an individual's capacity to perform those daily living tasks essential to a productive, satisfying life. The occupational therapist evaluates learning and performance abilities and seeks to teach those adaptive skills, behavior and attitudes crucial to independent and healthy functioning.[2]

Physical Therapist is a person licensed as a physical therapist in the state in which practicing and a graduate of an approved course in physical therapy. Physical therapy is concerned with the restoration of function and prevention of disability following disease, injury or loss of a body part. The goal is to train or retrain the person to perform activities associated with daily living. The therapist may use exercise, heat, cold, massage and corrective devices.[3]

Practical or Vocational Nurse is a person who is licensed as a practical (vocational) nurse in the state in which practicing. Licensing is based on the completion of a course in a community college or vocational school of 12-18 months. The practical nurse provides nursing care under the supervision or direction of a registered nurse.

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1. "Concepts of Community Health Nursing Practice Standards" - Community Health Nursing Practice. American Nurses Association, 2420 Pershing Road, Kansas City, MO 64108.

2. Allied Medical Education Directory 1974. American Medical Association, 535 North Dearborn, Chicago, IL 60610. P.294.

3. Ibid., p.316.

Handout 1 (continued)

Registered Nurse is a graduate of a state-approved program of professional nursing and is licensed after passing a board examination by the state in which he/she is practicing.[4]

Respiratory Therapist is a graduate of an approved program of a minimum of two years for preparation as a respiratory therapist. Performs procedures essential in maintaining the life of seriously ill persons with respiratory (breathing) problems and assists in the heart and lung ailments such as cardiac failure, asthma and emphysema. Under the direction of the physician, the respiratory therapist administers various types of gases, aerosol and breathing treatments.[5]

Social Worker is an individual who has received the formal education required to treat individuals, families, groups or communities with social and/or psychological problems in order to enhance personal satisfaction and well-being, and to prevent human suffering.[6]

Speech Pathologist (therapist) is a person who meets the education and experience requirements for a certificate of clinical competence and provides treatment for persons with speech disorders caused by physical defects, or mental disorders, such as aphasia or stuttering. When a stroke affects speech, a speech pathologist may provide treatment.

Supervisor is a person who provides procedural guidance for the accomplishment of a function or activity such as homemaker-home health aide activities with initial direction and periodic review to ascertain that the function is carried out as directed. Supervision includes instruction and teaching to improve functional ability.

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4. "Concepts of Community Health Nursing Practice Standards" - Community Health Nursing Practice. American Nurses Association, 2420 Pershing Road, Kansas City, M) 64108.

5. Allied Medical Education Directory 1974. American Medical Association, 535 North Dearborn, Chicago, IL 60610. P.294.

6. Guide to Planning, Organizing, Administering A Homemaker-Home Health Aide Service. National Council for Homemaker-Home Health Aide Services, Inc., 67 Irving Place, New York, NY 10003.

UNIT C: HOW THE AGENCY MAKES SERVICES AVAILABLE TO INDIVIDUALS AND FAMILIES

ESTIMATED TIME 1-1/2 hours

SUGGESTED INSTRUCTOR An agency director or supervisor, course instructor or case manager, social worker

INTRODUCTION

The homemaker-home health aide functions as an integral part of an agency that is organized to provide services in the community. Unit B described how the aide works with the individual and family and relates to the care team; this unit deals with the aide's relationship to the agency. It should provide the aide with an understanding of how the agency is organized, how it makes services available to the community, how decisions are made and how these affect and determine the activities of the homemaker-home health aide.

The material in this unit may be adapted to the differences that exist in local communities, and to the variations in agency programs, policies and methods of operation.

EXPECTED OUTCOME

The trainees will be able to:

- describe an agency or program that provides homemaker-home health aide services, its purpose and organization
- describe how an agency makes homemaker-home health aide services available to individuals and families by:
    - establishing procedures and policies
    - developing plans of care based on need and assessment by professional staff
    - providing supervision and guidance
- describe the responsibility of the agency to the aides and staff

- identify how the aide functions in delivering services.

CONTENT

To work effectively as part of an organized program, the trainee needs to be familiar with the agency and its operation. Discussion of the following principal areas will help achieve this purpose.

Part 1: Organization of the Agency *

This presentation may be based on the structure of a local agency or organization that may be employing homemaker-home health aides. If training is conducted outside these agencies by a community college or other source, Part 1 should be presented by the director of a local homemaker-home health aide service. This Part may also be handled prior to training by agencies delivering homemaker-home health aide services.

This should include:

- history and purpose - when and why it was established
- structure and administration - legal basis for authority
- personnel within the agency home services unit or department
- sources of funding.

Part 2: The Delivery of Service by the Agency

This topic is concerned with how services to individuals and families are determined and delivered as based on program policy.

Policies and procedures may include:

- eligibility criteria - who may be served by the program; priorities of service and restrictions such as distance, age, diagnosis, source of payment

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*A Guide to Planning, Organizing, Administering a Homemaker-Home Health Aide Service. National Council for Homemaker-Home Health Aide Services, Inc. New York, NY: Section IV, Structuring an Agency, and Section VI. Delivering Services, may be useful resources for the instructor.

- referrals - who may request service and how should requests be made; when must a physician endorse the request and prescribe the services needed

- relationships with other agencies and resources in the community necessary to provide for the total care needs of individuals and families; e.g., are there contractual arrangements with the health department or home health agency for nursing service or physical therapy, or with the family service agency for counseling

- assessment of need and the development of a plan of care that defines what and how services will be delivered.

The responsibility for accepting or rejecting requests for service, the assessment and reassessment of need, the initial and subsequent modification of the plan of care and the schedule for providing service rests with the professional staff. The homemaker-home health aide contributes to decisions by sharing observations and reporting to the supervisor.

The professional staff considers the following factors in reaching decisions about the type and amount of service to be given:

- the health and physical condition of the person and family members, medical care, diagnosis and treatment

- the social situation - ages and relationships of members of the household, adequacy of housing and financial resources as related to the care needs, reactions of the individuals and family to the problem(s) and to the need for service, availability and willingness of family members to assist with the care, other family problems and past ability to cope with crisis situations

- the anticipated duration of service and expected outcome

- the other services or resources which may be needed, e.g., specialized equipment, supplementary income, transportation.

Based on the assessment of individual and/or family strengths and defined need, goals for service are established and a plan of care is developed to achieve them. The plan of care includes activities to be performed, days and hours that service is to be provided and special instructions for the aides as may be appropriate. The plan should also include what professional staff will do and what other agencies will do, e.g., "home delivered meals five days a week." *(The instructor may use Handout 1 or a comparable plan of care as a basis for discussion.)*

The supervisor prepares the homemaker-home health aide for each assignment. Preparation should include sufficient information about the family, its strengths and its problems, to serve as a basis for understanding the need for the service and its expected value to the family. An explanation of the goal(s) of service helps the aide understand the purpose and importance of the activities that are to be performed. Understanding the goals results in a feeling of satisfaction where there is progress and helps to signal lack of progress that should be reported.

In addition to instructions concerning home maintenance activities and personal care tasks to be performed, the aide also needs to understand the characteristics of the individual or family members. When other professional personnel are involved in the care plan, the relationships and what specialized services are to be provided should be understood by the homemaker-home health aide.

The decision to terminate a service is as important as the decision to start it. Factors influencing the decision to terminate include the wishes of the family, the degree of progress toward agreed-upon goals and the family or individual's ability to maintain themselves independently. It often happens that service is gradually decreased as capacity for self-care increases. In reaching the decision, the professionals use their own evaluation, that of the physician, the observations of the homemaker-home health aide and the readiness of the family. The homemaker-home health aide should be made aware of the decision before it is finally discussed with the family.

The aide may experience different reactions when services are discontinued or assignments changed. Strong attachments may make it difficult to leave a family. On the other hand, the aide may be glad to leave a troublesome situation. Discussion of these feelings in an atmosphere of acceptance will help the aide and the family in their adjustment to the change and to better understand the homemaker-home health aide role as a helping person.

Part 3: Responsibility of the Agency to the Homemaker-Home Health Aide

This part further clarifies agency policy related to the work of the homemaker-home health aide and the supervisory process.

To fulfill its overall mission, the agency must assure itself that its staff members have the information, competence and tools necessary to carry out their respective responsibilities. This is reflected in the following policies and procedures:

Job Descriptions. Written job descriptions for each category of staff help to insure qualified and competent staff. The job descriptions also state the agency's expectations for each staff member.

Training. Initial generic training for homemaker-home health aide and an ongoing in-service training program maintains and improves knowledge and skills. This assures quality care for persons and families served and the growing competence of the aide.

The basic training should include an orientation to the agency, its policies and procedures, and a discussion of the supervisory process.

Supervision. The process of supervision and how it is used must be clearly understood. The enabling and administrative aspects of supervision should be explained and discussed to help the trainee conceptualize the relationship of supervision to services. The teaching or enabling aspect includes both individualized "how-to" instruction and help in understanding the use of oneself effectively. By eliciting what the trainee already knows, the supervisor helps apply that knowledge to new circumstances, provides instruction and offers suggestions and alternatives. For example, by identifying what the aide already knows about balanced diets, the hazards of crossing a street or the kinds of feelings experienced when tired or sick, the supervisor builds on that knowledge in helping the homemaker-home health aide prepare a special diet, accompany a blind person, or work with an ill, depressed, demanding or critical person.

The administrative aspect of supervision involves making certain that all staff, including the homemaker-home health aide, carry out the goals, policies and procedures as defined by the agency.

Supervision may be conducted on an individual or group basis. The homemaker-home health aide needs to know when supervisory conferences are to be held, the matters to be discussed, how supervisory assistance can be obtained between scheduled conferences and when and why supervisory home visits are to be made.

Policies and Procedures of An Agency. *(See Exhibit 1)* The discussion of policies and procedures should include basic concepts applicable to all agencies. These include: confidentiality, personnel policies and service policies and procedures.

- Confidentiality should be stressed as a responsibility incumbent upon all members of the agency and helping professions with respect to individual and families served and the handling of personnel and case record files within the agency.

- Personnel Policies should be in written form and a copy given each staff member. Good personnel policies protect the homemaker-home health aide directly, the community and those served indirectly by attracting and keeping good staff and maintaining a sound basis of operation. Matters for discussion include benefit structure, performance appraisal, pay periods, grievance and appeals procedure, personal grooming and dress requirements, opportunities for advancement and further training.

- Service Policies and Procedures relate to the day-to-day performance of the homemaker-home health aide on the job. *(Each agency will want to include its own set of policies; however, the following would be generally applicable to* *all agencies.)*

- adherence to the details of the assignment, especially in regard to punctuality, is a basic concern of the agency. Families and individuals in need of home care service depend on those assigned to help them. They are already fearful and anxious because their security has been threatened. The plan of care has been carefully constructed to meet the needs of the individual or family. If changes are requested by the family, or if a change in hours or duties is indicated, this should be talked over with the supervisor.

- reports to the supervisor are made at specified intervals or more frequently if indicated. Important events or changes in the family, an accident on the job, illness which prevents the homemaker-home health aide from going to the assignment or an unavoidable delay should be reported promptly.

- personal problems are not to be discussed with the person or families being provided service. The homemaker-home health aide is in the home as a helping person to provide support and assurance to those being served.

- giving or receiving gifts is prohibited by most agencies. It detracts from the professional nature of the service and may result in complicated relationships. Some problems which might occur: the person forgets giving the gift and may suspect that it was stolen; a tendency develops to expect something extra with subsequent resentment if it is not received.

- precaution is to be exercised in handling money, if this is required by the care plan. Some precautions include: obtaining receipts, returning change promptly, counting out the amount to the person, etc.

Part 4. Functions and Responsibility of the Homemaker-Home Health Aide

How the homemaker-home health aide functions as part of the social/health care team is the next topic for discussion.

The homemaker-home health aide is a core member of the home care team. She/he makes a unique contribution to families and individuals, to the community and to the home care team. Knowledge and skills are concentrated on helping people who need help in order to be at home.

As a teacher, the homemaker-home health aide is a role model in all the families with whom she works. She teaches indirectly by example and by demonstration, regardless of the reason for the service. There are many teaching opportunities in the course of a day's activities, such as the way the homemaker-home health aide speaks to a child, the way time is used, how the homemaker-home health aide involves family members in the tasks to be done and how scarce resources are managed. There are, however, special situations in which the homemaker-home health aide is called upon in a direct and purposeful way to teach, such as self-care skills to a visually handicapped person, or child care and home management skills to an inexperienced mother.

As a team member, the homemaker-home health aide participates in the implementation of the plan of care by sharing observations, problems and changes with the supervisor and appropriate members of the home care team. Inclusion in both intra- and inter-agency conferences and case reviews gives recognition to the contribution the homemaker-home health aide can make not only in identifying what the family needs but in identifying community needs and stimulating agency action to meet these needs.

AIDS

Exercise 1: Team Approach and Plan of Care

Exercise 2: Discussion of Plan of Care

Exhibit 1: Agency Policy and Procedures

Handout 1: Model Plan of Care

Discussion Questions 1: Understanding the Responsibility of the Agency and the Role of the Homemaker-Home Health Aide

Exercise 1: Team Approach and Plan of Care

This exercise would require a panel presentation by professional staff including a homemaker-home health aide from a service team. Each team member would be asked to discuss their respective responsibilities in the case process from the point of intake through assessment, setting the plan of care, and assignment to the homemaker-home health aide.

Exercise 2: Discussion of the Plan of Care

The plan of care will be discussed in order to familiarize the trainees with the plan and its use in service delivery.

- Hand out the model plan of care.
- Discuss each type of information, why it is included, what it means for the homemaker-home health aide, etc.
- Hand out a sample plan of care based on a case situation that can be described for the trainees.
- Discuss the role of the plan in the provision of service.

Exhibit 1: Agency Policy and Procedures

Confidentiality

Personnel Policies

Service Procedures and Policy

- Punctuality
- Adherence to Details
- Supervisory Reports
- Personal Matters
- Gifts
- Handling Money

Handout 1: A Plan of Care for Mrs. Roberts

Mrs. Roberts, aged 75, returned from the hospital on Thursday of this week following hospitalization for treatment of severe ulcerations on her legs because of old varicose veins, poor circulation and edema related to a congestive health condition. She was unaware of the developing heart condition thinking the shortness of breath was because she was getting older.

Prior to her hospitalization, Mrs. Roberts has lived in the same five-room house which the family owned for 40 years. She has always been active in the neighborhood church and its organizations. She had not been attending as many activities during the last few months because of difficulty in walking due to her sore legs and shortness of breath.

Her husband died two years ago and one daughter lives across town. The daughter works and has a family. She was always closer to the father and does not come as often since he died. Another daughter and son live in another State.

Since her illness, Mrs. Roberts has been withdrawn and listless. Her appetite is poor and she dislikes the low sodium diet. Sometimes she forgets to take her medication. Although improved, the ulcers on her legs still require dressing and should be kept dry. She can now wear shoes, but still has some shortness of breath. She has been slow to regain strength and seems unable or uninterested in preparing meals and keeping the house neat.

She says she wants to see friends, but never does call them. Mr. Morens, an old friend of her husband, has been her most frequent visitor and tries to cheer her up. The daughter is not pleased by this friendship.

Formulation of The Plan of Care

Assessment of need in the context described, and of the complex of services required to meet that need, can be precisely formulated. The following is the plan developed for Mrs. Roberts.

In Health Care: Goals

Increase ambulation; work toward self-help with dressing and bathing.

Improve nutrition; encourage participation in meal planning.

Work with present depression and attempt resumption of social contacts.

Involve adult daughter in plans.

Services:

Nursing:	Miss Anderson is to visit twice a week for dressings and to help with bath at first. Homemaker-home health aide to take this over. Discuss special diet with nutritionist and homemaker-home health aide. Visits to be made around 10:00 a.m. if possible.

Social Work:	Mrs. Rubens will try to reach adult daughter. Homemaker-home health aide to note depression; encourage her to have friends visit as they did before her illness.
Homemaker-Home Health Aide:	Mrs. Sorbin to visit four hours three time a week; Monday 8-12 noon Wednesday 1-5 p.m. (accompany to medical appointment 1:30) Friday 1-5 p.m.
Homemaker-Home Health Aide Activities:	Basic cleaning: kitchen, bath, persons bedroom (priority), dust, vacuum other rooms as possible. Shopping (telephone for list before coming). Laundry to laundromat. Food: lunch and dinner each Monday, Wednesday and Friday and casserole for Tuesday and Thursday, plus puddings, salad, wrapped sandwiches for lunch Tuesday and Thursday. (See special diet.) A neighbor provides her meals on weekends. Check cashing (every two weeks). Pay utility bills monthly at bank near supermarket. Thirty minutes in backyard Monday and Friday when weather is warm. Finances: limited -- check with office for special needs or if there are shortages for basic needs.

The O'Malley Family

Following the birth of her sixth child, Mary (her oldest daughter being only 12 years old), Mrs. O'Malley developed phebitis in her left leg and became very depressed. Her mother had died with a "blood clot" following childbirth. Mrs. O'Malley was transferred to the hospital psychiatric unit with a diagnosis of post-partum depression. Mrs. Gomez, a homemaker-home health aide, was assigned to care for the family while the mother was in the hospital. This meant that the four older children could continue in school and the father could continue working the shift. The new baby is being cared for by the husband's sister in her own home.

In Child Care: Goals

Encourage Mr. O'Malley's participation in establishing more normal routines, particularly for youngest child.

Encourage discussion of mother's illness; reinforce assurance that she will soon be home.

Work toward a moderate routine of "chores" for older children to be continued on mother's return.

Alert school personnel and discuss Mary's school progress.

Visit the hospital every two weeks to plan with mother for convalescent and ongoing routines in home.

Initiate health care for all family members.

Services:

Social Work:	Visit twice weekly; after school with children; after work with father; weekly with mother in hospital.
Public Health Nurse:	To check immunization and initiate pediatric supervision.
Homemaker-Home Health Aide	Daily 2-6:30 (or until father comes home).
Homemaker-Home Health Aide Activities:	Food shopping en route at supermarket (milk is delivered). Laundry - twice weekly. Sheets go out every two weeks. Washing machine available. Limited ironing. (Father's shirts--priority.) Household maintenance -- general -- as possible. Older children may be encouraged to help with bathroom and kitchen. Father does heavy work (carpets, floors on weekends, and will bring in heavy grocery staples if homemaker-home health aide prepares list). Wednesday: dental appointment every two weeks at 4:15 p.m. Older girl will supervise. Finances: Father will provide weekly food allowance. Pays all utilities. Special problem: check bed of six-year-old (eneuresis recently controlled; may recur). Report to social worker; do not comment to child. Encourage participation of children in moderate household routines and in plan for mother's return. Reassure regarding mother's return at every opportunity.[*]

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[*] Trager, Brahna. *Homemaker-Home Health Aide Services in the United States.* Department of Health, Education and Welfare, No. HSM 73-6407, June 1973.

Discussion Questions 1: Understanding the Responsibility of the Agency and The Role of the Homemaker-Home Health Aide

What does a supervisor do?

What comes to your mind when you think of having a supervisor?

What kinds of things -- problems, questions, events -- does your supervisor need to know about?

What things would you not want to tell the supervisor?

What use is made of the information you tell the supervisor?

What is the role of the supervisor on the team?

Describe some functions of the homemaker-home health aide.

List tasks that a homemaker-home health aide might teach or demonstrate.

Indicate the homemaker-home health aide's contribution as a team member.

What is the homemaker-home health aide's role as a catalyst?

UNIT D: HISTORICAL BACKGROUND AND GROWTH OF HOMEMAKER-HOME HEALTH AIDE SERVICE

ESTIMATED TIME: Optional (about 1/2 hour)

SUGGESTED INSTRUCTOR: Social worker, course instructor.

INTRODUCTION

The trainees are beginning to prepare themselves for a whole new career. Their motivation can be heightened by bringing to them an awareness that this career is part of both a national and an international movement into more person-oriented health and social service care. Moreover, the movement is growing in numbers of persons involved, and in the significance of its work.

EXPECTED OUTCOME

The trainee should be able to:

- Name the countries where the service was first established
- Describe the increase in number of service programs and in homemaker-home health aides in the United States since the service first began
- Repeat the ways in which others have expressed personal involvement with their work, but in their own words

MATERIALS/EQUIPMENT

Flipchart, movie projector

CONTENT

Part 1: International Homemaker-Home Health Aide Service

Homemaker-Home Health Aide Service is one of the basic social and health services. It is one of the most rapidly expanding of these services. The phrase "homemaker-home health aide" describes this worker in the United States, but you will find that the word "homehelp," spelled as one word, is the term most used in other countries.

The International Council of Homehelp Services (ICHS) was founded in The Netherlands (Holland) in May of 1959. They describe homehelp work this way:

> "To look after a family or single person in their own homes in case of illness, incapacity, absence of the father or mother, pregnancy, age or other causes."

This description applies whether the service is performed by private or by public organizations, and the description assumes that the service is performed by trained persons working under skilled supervisors.

Each country describes the service in a slightly different way. The definition of homehelp service is affected by the fact that most of those served are elderly. In some countries there may be an emphasis on caring for the expectant mother, or the family where there is no mother present, or in the home in which there is illness.

The first program to provide services in the home in Europe was organized in Frankfurt, Germany, in 1892. Good ideas do not wait long for repetition, and this one was no exception. A similar program was started in London in 1897.

Since the end of World War II, European governments have been deeply involved in various ways with the growth of homehelp services. This activity and concern has accelerated the growth of service in Europe. This involvement has also given the service a new and higher status: it is regarded as an essential service. Homehelp workers are respected highly, and their work conditions are protected. The result is that in most European countries working as a homehelp is regarded as a very desirable occupation.

Training is strongly emphasized in Europe. The longest period of training is required in West Germany, where students train for a whole year in a residential school, then work for another year under supervision in hospitals, homes for the aged, childrens' institutitions and in private households. Six other countries have requirements written into the law for training periods ranging from 15 to 20 months, a large portion of this time is spent in supervised, on-the-job training.

Part 2: History and Growth of the Service in the United States

The stage was set for homemaker-home health aide services as we know it in this country at the beginning of this century. At that time, "visiting cleaners" were sent into the homes of sick and poor mothers in New York City to supplement the nursing services they were already receiving. About twenty years later, in Detroit, one of the first programs for "visiting housekeepers" was started. These persons taught food preparation and nutrition, primarily, to inexperienced and economically deprived mothers.

The first truly organized homemaker program was started in 1923 by the Jewish Welfare Society of Philadelphia. They chose "motherly women" to care for children at home when the mother was in the hospital.

During the years of the Great Depression (1930-1940), the federally financed Works Progress Administration (WPA) employed women as "housekeeping aides" to help with the care of children and, incidentally, provide jobs for these women. By the time the WPA was discontinued as a Federal program (in 1941-1942), there were 38,000 homemakers in the United States. The withdrawal of Federal funds created a crisis at the time, since most communities were not financially prepared to continue the services. To meet the continuing need for services, voluntary family and children's services carried on homemaker programs during this period.

By 1959, when a national conference on homemaker services was convened, it had become clear that the need for these services persisted and was not being met. The purpose of the meeting was to find ways to stimulate the development of more services. At about the same time, the results of a national study of homemaker services showed clearly that more than 80 percent of the households receiving homemaker services had one or more persons in them who were ill. Therefore, another national conference was sponsored by the National Health Council in 1960 to discuss personal care. This conference resulted in guidelines for the kind and amount of personal care that homemakers could give to the ill and disabled; it also resulted in guidelines for the training and supervision needed to ensure efficient and safe care.

A year later, in 1961, representatives from the 1959 conference met again to reconsider the development of the service in the light of the personal care conference the year before. It was decided that the service was ready for vigorous national promotion. The outcome of this meeting was a formal request to both the National Health Council and the National Social Welfare Assembly to create an independent national agency that would work for the development of homemaker services, set standards in the field, provide consultation to agencies and undertake research when needed to increase the knowledge of and the need and impact of homemaker services. The National Council for Homemaker Services was incorporated in 1962.

A significant event occurred in 1965: the advent of Medicare. This provided a stimulus for the development of home care services, including home health aide services. Both the Federal program and home care services have been growing ever since, with various legislative actions to modify and direct it.

The importance of home health care, and the careful definition of personal care services developed in 1960, were among the factors prompting a change in name of the National Council for Homemaker Services to the National Council for Homemaker-Home Health Aide Services in 1971 (emphasizing the links between the homemaker and home health aide services -- links so close that the National Council believes that both belong to the same role). The name change emphasized also the increasing importance of providing in-home services to people who are ill or disabled. The standards of the National Council call for training to prepare the homemaker-home health aides to carry out both homemaking and personal care responsibilities with confidence and competence, and under appropriate supervision. These standards, and the monitoring of the standards, were formalized in 1972 in an Accreditation Program, whose purpose is to disseminate both functions uniformly throughout the country.

All of the steps that have been taken, and described above, have had the purpose of directing the growth of programs to offer quality in-home care services, and growth in the number of homemaker-home health aides to meet the growing and demonstrated need. The last two decades have seen remarkable changes. There were only 150 programs in 1958; today, there are nearly 5,000 programs providing some aspect of the service. The growth in number of homemaker-home health aides has been equally remarkable: 3,900 in 1963; 11,400 in 1968; 44,000 in 1972; and about 82,000 today. Nor is the pace slowing, for the United States has need for about 300,000 homemaker-home health aides within this decade.

UNIT E: OVERVIEW OF THE TRAINING PROGRAM

ESTIMATED TIME: 1/2 hour

SUGGESTED INSTRUCTOR: Coordinator or instructor of the course.

INTRODUCTION

An overview of the training course allows the opportunity for the coordinator/instructor to tell what the various parts of the course will be. It also allows the trainees to test their expectations against what will be taught; to assess their present skills; to indicate their areas of specific need for new skills and knowledge; and to influence the instructor in the particular mix he or she will present in the course.

EXPECTED OUTCOME

The trainees will be able to:

- express their expectations and needs in detail
- describe what skills and knowledge the training course will provide and to relate their expectations to the course elements

CONTENT

Reviewing the list developed in Unit A, Exercise 1, and the list developed in Unit B, along with role-playing and discussion of the case studies, can accelerate the growth of awareness of expectations and of need for knowledge and skills. There may be sentiment expressed about adding to the lists already developed. When this is done, the instructor can use the opportunity to show how the training course will help to fill in the gaps identified by the trainees. You can refer to Exhibit 1, which outlines the program content areas, to help you.

The sections and units of training during the coming classes will cover the following areas:

II - Working With People

III - Home Management

IV - Personal Care

V - Supervised Field Experience

Section II -- Working With People, will last about 20 hours. It gives trainees a deeper understanding of the basic physical and psychological needs everyone has. It will help give insight into the ways in which the individual strengths, life experience and acquired skills of individual trainees can be used to help others whose basic needs have not been met, or whose needs are threatened in some way. The understanding and insights developed will be applied in several contexts: working with children, working with older adults, working with persons who are ill; working with those who are physically disabled and, finally working with those who are mentally ill.

The following two sections, III and IV, will focus on acquiring the practical knowledge and skills to carry out the purpose of working with others.

Section III -- Home Management, will take approximately 17 hours. For most trainees, it refines and systematizes what they know and have practiced in maintaining a home, planning and preparing meals and managing budgets. The impact of good management in these tasks on the person or household served will be emphasized. Moreover, the trainees will have an opportunity to realize that their own "ways" of performing tasks, even if they are efficient, may have to be altered to accommodate to the wishes of the person served, or the needs of the professional plan of care developed for the household. There are some important differences in they way one cares for one's own home and the way one cares for someone else's home; learning that difference and coping with it is one of the purposes of Section III.

A subject of particular importance in this section also is that of diets and nutrition. What is learned in this Section will allow the trainee to cope with special diet requirements that may be called for in the plan of care.

Section IV -- Personal Care, takes about 19 1/2 hours. It will deal in detail with the knowledge and the skills required in giving personal care to individuals. There will be ample opportunity to watch the skills performed, and to practice them, in the classroom.

This Section will also be focused on the human body; its functions, recognition and evaluation of body changes, how to take body temperature and record the reading, and taking the pulse and respiration. Most "how to" procedures will involve the body; preventing the spread of disease; the use of good body mechanics in positioning the person in bed, assisting a person who is weak and ill in getting from the bed to the chair or into a bathtub are examples of procedures that will be learned.

In Supervised Field Practice, Section V, trainees will begin to employ the knowledge and skills they have learned in the course. The plan of care will be described in general terms, and the several parts of it already dealt with in previous Sections will be integrated in a general way. Field practice is the opportunity for putting together the skills and knowledge learned already and applying them in a home setting. It should be considered an additional learning experience.

Selected References

Addenda to Standards for Homemaker-Home Health Aide Service. New York: National Council for Homemaker-Home Health Aide Services, Inc. 1969, P. 30.

Focus on the Future, A Ten-Year Report 1962-1972. New York: National Council for Homemaker-Home Health Aide Services, Inc. 1973.

A Guide to Planning, Organizing, Administering A Homemaker-Home Health Aide Service. New York: National Council for Homemaker-Home Health Aide Services, Inc. 1979.

Standards for Homemaker-Home Health Aide Services. New York: National Council for Homemaker-Home Health Aide Services, Inc. 1965, P. 48

Trager, Brahna. Home Help Abroad - A Review of Selected In-Home Services in Western European Countries. New York: National Council for Homemaker-Home Health Aide Services, Inc. (Rev.) 1971.

A Unit of Learning About Homemaker-Home Health Aide Services, Teachers Source Book. New York: Co-published by Council on Social Work Education and National Council for Homemaker Services, Inc. 1968, p.191.

Widening Horizons - A Guide - The Teaching Aspect of Homemaker Service. New York: National Council for Homemaker-Home Health Aide Services, Inc. 1974.

Winston, Ellen, Ph.D. "Homehelp (Homemaker) Services." A paper presented to the 15th International Conference on Social Welfare, 1970. New York: National Council for Homemaker-Home Health Aide Services, Inc. 1975.

Exhibit 1: Training Program Outline

1. Working with People
2. Practical Knowledge and Skills in Working with People
3. Supervized Field Practice

SECTION II

WORKING WITH PEOPLE

The purpose of this section is to provide a deeper understanding of the basic physical, emotional, and mental needs that everyone has. The real value of that understanding and insight, however, will be found in the ability of the trainee to apply what is learned to situations in which these basic needs must be satisfied in circumstances somewhat out of the ordinary: when the person served is a child, an older adult, someone ill or disabled, or when someone is mentally ill. With this understanding the effectiveness of services delivered to a person or family in the home will be greatly enhanced. In part, this is a matter of empathy: the trainee can learn to appreciate that someone who is ill, disabled, or in social circumstances that threaten independence and the ability to cope with problems and crises needs the help that the homemaker-home health aide can supply in just the same way that the trainee would appreciate that kind of help. This is the secret of success in working as a homemaker-home health aide. And the basis for this success is the ability to communicate with others.

UNIT A: COMMUNICATION

ESTIMATED TIME: 1 hour

SUGGESTED INSTRUCTOR: Social worker, psychologist, mental health consultant, or communication specialist

INTRODUCTION

In ordinary life, the communication between two people can be relatively "loose" and imprecise, and no dire consequences result. In fact, the imprecision can stretch out the time for completion of a "message" between them, and doing that defines much of the character of daily social life. A person or household coping with unusual circumstances, however, has little extra energy left over; the need is to achieve understanding and agreement on what is wrong and what must be done as quickly and accurately as possible. Moreover, the skill with which this is accomplished may tilt a delicate relationship or attitude in one crucial direction or another. Learning how to get to the heart of things by asking a few questions and by responding skillfully to others is a skill that is part of applying what is learned of home management and personal care techniques.

EXPECTED OUTCOME

The trainee will be able to:

- identify the ways in which people communicate with each other
- describe the difference between verbal and nonverbal communication
- describe how communicative skill of the homemaker-home health aide helps assure the provision of in-home care to persons and families
- describe ways in which to practice the achievement of better skill in communicating with others.

CONTENT

Part 1: Concepts of Communication

Exercise 1 or a similar case may be used to demonstrate how communication influenced the work of the homemaker-home health aide.

The word "communication" can be defined in many ways, some of which involve only two persons, some of which involve many persons interacting at once. Let us consider the simplest, but perhaps the most important, case: exchange of some significant information between two persons. The significant information is called a "message"; the person who communicates first is called the "sender"; and the person to whom the communication is sent is called the "receiver". You can see that the roles of sender and receiver may be in constant interchange as first one person, then the other, speaks, and hopes that what is said is understood and absorbed by the other person. Social scientists have devoted much attention to this apparently simple process; until one begins to appreciate the subtleties involved, it is hard to believe that the process is as yet incompletely understood. But what is clear is that the simpler and more precise the message, the greater the likelihood that the receiver will understand and interpret the message correctly (that is, in the sense in which the sender intended). Most contacts between people involve speaking the message, even if that message is only a greeting like "Good morning!" You can appreciate the complexity involved right away if we point out that you know as well as we do that the way in which that greeting is given can convey a world of meaning to the receiver!

That very fact leads to the next point, which is that a message, the content of a communication, may be verbal or it may be nonverbal. Speech and language are most often associated with the word "communication". Yet communication may occur both through words and through other ways ("body language", intonation, the looks that accompany the speech, and so on). Some of these other nonverbal messages may actually convey more meaning than the spoken words. If someone growls at you in saying "Good morning!" you will receive a very different message from the one when someone smiles at you while saying it and throws her hands wide in the air. Think of how different a simple greeting like "good morning" can become if it is accompanied by a touch of a finger on an arm and a facetious smirk delivered with a sideways glance.

Some nonverbal communications are quite neutral, however, as when a child or adult will point at an object or person to define what he or she means. Gestural communication can become very complex, as in the case of the sign language of the deaf. Somewhat less orderly, but not necessarily less complex, are the gestures or even noises that are characteristic of the way a person directs messages to others; we call these "mannerisms", and they are among the most potent ways of recognizing the individuality of someone else. But paramount among the nonverbal means of communication is the technique of eye contact, or avoidance of eye contact. Whole mythologies, whole systems of interpreting the speech and gestures of others, have been based on whether eye contact is maintained during the period a message is sent or not. Finding out what another person believes is the "meaning" of eye contact, and acting accordingly, may be a key to success in some situations. To most Americans, "looking someone straight in the eye" is the only way to make oneself believable when one is speaking; doing that to a superior in Japan would be to insult him. Thus, culture and context become important determinants of the meaning of nonverbal gestures and techniques.

The verbal and nonverbal represent complexities of communication. In returning to the simple written word, concern is with a more common problem: making one's meaning clear in stating something in writing. What is perhaps most important to keep in mind is that when a homemaker-home health aide writes down an observation about an event, it should be described in the simplest and clearest way possible; no attempt should be made to interpret and evaluate the event unless that is asked for later. The same rule applies to all the records that are kept in making visits to persons in their homes.

Part 2: How the Homemaker-Home Health Aide Uses Communication

Exercise 2 may be used to demonstrate situations in which the homemaker-home health aide uses communication.

Communicating by using both verbal and nonverbal means may be considered the equivalent of "presenting" your self to another individual. The combination of what you say, the way you say it, and the things you don't say but do while you're saying it—all these in combination make up the impression you make as a person on another person. There are many ways in which this kind of presentation of the self will influence the way in which the homemaker-home health aide impacts on the person or family to be served. Among them would be:

- introducing yourself upon the first visit to an individual or family creates a relationship with that individual or family

- giving and receiving of messages both verbally and nonverbally is the basis upon which the homemaker-home health aide gains an insight into and an understanding of the circumstances affecting the individual and the family—and the ways in which the homemaker-home health aide can help them

- finding out quickly what the condition of the individual or family is at a given moment in time, and establishing what the desires of that individual or family might be

- explaining clearly and simply what procedures will be used in bringing personal care and other services to the persons in the home

- teaching the persons in the home good home management and self-care

- reporting what the homemaker-home health aide has done in the home on a given occasion, and reporting observations that may affect the carrying out of the plan of care developed by the professional team or the supervisor.

Part 3: How to Communicate Better

Fortunately, there are ways in which one can learn to communicate better. It is a learned skill. You can become sensitive to the ways in which messages are sent and received, and clarify the content of messages so that they are received quickly and accurately, by practicing constantly some of the following techniques:

- speak more slowly than you do in conversing with friends and family; be sure each word is spoken clearly, especially when you are speaking to someone hard of hearing or to someone whose native language is not English

- learn to listen! Be patient until the message is completed by the sender, even if the sender has a hard time stating the message; time saved here is time earned later; you will also find that others consider you a good "talker" if you are a patient listener; if you don't understand something that is said, don't wait; say "I don't quite understand what you mean" or "It seems you mean that..."; you'll quickly find out that if you are not receiving the message accurately, the sender will make a correction until you do

- unless you share the cultural background of a person from another culture, don't try to use the words and phrases from that culture; some of the words and phrases may have special meanings that you are not aware of, and you may end up conveying the wrong message; this is not to say that you should not learn the meaning of new words and use them as the person teaching them to you intended: the whole point of special vocabularies—lists of special words—is that once their meaning is agreed upon, time and effort can be saved in communicating; thus, if an older person complains to you that she has been "suffering the ague" (aig-yoo) since your last visit, and you determine that this is meant to say the person has been suffering pains in the limbs and general chills—then by all means use the term to cover these complaints; learning the meaning of special terms in other cultures is a nonverbal message to the person you are helping that you value his culture and his message and that you have received it accurately

- try to report events and observations in simple words and simple sentences; defer interpretation until discussion with your supervisor; to recall an earlier case study, you might record that "... Betsy has been drinking more fluid than any other child in the household and constantly asks for more soda". That may be an important clue to the supervisor that Betsy may be a diabetic; at least it will alert someone to this possibility, so that it can be explored.

ASSESSMENT

1. When a message is spoken by a sender and heard by a receiver, it is called

   ____

2. Communication may be ______________ or ____________________.

3. List four nonverbal methods of communication:

   ___________________________ ___________________________

   ___________________________ ___________________________

4. Name three ways in which people may communicate with each other:

   ___________________ ___________________ ___________________

5. List five ways in which the homemaker-home health aide uses communication skills in providing service:

   ___________________ ___________________ ___________________

   ___________________ ___________________ ___________________

   ____

6. List four techniques the homemaker-home health aide can use in improving and insuring better communication with persons and families served and with other staff members:

   ___________________________ ___________________________

   ___________________________ ___________________________

ANSWERS

1. Communication
2. Verbal or nonverbal
3. Smile, frown, gesture, touch, body stance, pointing
4. Speech, written word, gestures
5. Establishing relationships, gaining insights, explaining procedures, teaching, reporting
6. Speaking clearly and slowly, listening attentively, allowing person to complete statements, avoiding use of words that may have special meaning, learning meanings of new words

AIDS

Exercise 1: Discussion of Communication Skills

Exercise 2: Demonstration of Communication Skills

Handout 1: Situations in Which Communication is Important

Handout 2: Guidelines for Effective Communication

Exercise 1: Discussion of Communication Skills

Using Exercise 2, Section I, Unit B, "The Mason Case Story", or another case situation, focus discussion on the importance and use of communication skills. The discussion might include such factors as:

- physical problems in communication
- interpreting the purpose of the service
- methods used by the homemaker-home health aide in gaining acceptance.

The Mason case may be used to role-play on the use of communication skills. Several homemaker-home health aides may alternate the roles of Mrs. Mason, the supervisor and the homemaker-home health aide.

Exercise 2: Demonstration of Communication Skills

Have the class form groups of three, alternately taking turns as sender, receiver and observer of the communication that takes place. The observer will note:

- the clarity of the message and the communication skills used
- how the receiver interpreted the message: did the receiver understand the message as intended?

Statements and/or situations such as the following may be used:

- "My name is .... I am the homemaker-home health aide" (introduction on entering a home for the first time).
- The homemaker-home health aide arrives in the home to find the elderly Mrs. James still in bed, having had no breakfast; what would you, as the homemaker-home health aide, say?
- It is lunch time, but Mrs. Jones says that she is not hungry yet, when the homemaker-home health aide brings the tray; what would you, as the homemaker-home health aide, do?
- Mrs. Merrit complains that the homemaker-home health aide did not clean the kitchen correctly; how would you, as the homemaker-home health aide, react?

Demonstrate how the sweeping of the floor by the homemaker-home health aide may convey three distinct messages to the person served.

Handout 1: Situations in Which Communication is Important

The homemaker-home health aide uses communication skills in:

- establishing and maintaining relationships
- gaining understanding of circumstances affecting the family
- explaining procedures
- teaching home management
- reporting activities

Handout 2: Guidelines for Effective Communication

Methods the homemaker-home health aide may use in communication with individuals and families include:

- speaking clearly
- speaking slowly
- listening
- allowing person to complete statements
- avoiding use of words with special meaning
- learning the meaning of new words
- recording and reporting accurately

UNIT B: UNDERSTANDING BASIC HUMAN NEEDS AND THEIR RELATIONSHIP TO HOMEMAKER-HOME HEALTH AIDE SERVICES

ESTIMATED TIME: 3 hours

SUGGESTED INSTRUCTOR: Social worker, psychologist

INTRODUCTION

This unit forms the basis for other units within the section "Working With People." It deals with basic differences among individuals and families and introduces the homemaker-home health aides to the unique contributions they can make to the lives of others.

EXPECTED OUTCOME

The trainees will be able to:

- describe some basic needs which homemaker-home health aide service helps to meet
- identify situations which might need homemaker-home health aide service
- describe the importance of the family to individuals and to society
- describe how people may feel when basic needs are not met.

MATERIALS/EQUIPMENT

Projector, screen, films, flipchart, blackboard, chalk, and eraser.

CONTENT

Part 1: Basic Human Needs

The instructor should refer to Exhibit 1 for discussion of Basic Human Needs.

To work effectively with people, we need to understand some things about ourselves and about others. No two people are exactly alike, yet there are certain needs common to all, regardless of age, race, economic status, nationality, education or religious belief. Physical or biological needs, such as food, clothing, shelter, rest and activity, avoidance of pain and the instinct to escape danger are essential to our health and survival. *(See Exhibit 1.)*

Our psychological needs are for emotional, mental, spiritual, intellectual and social growth and development. The degree to which they are met will determine our sense of well-being.

- love and affection demonstrated by sensitive care and interest

- recognition and acceptance that promotes self-respect and self-worth (to be needed or useful)

- security and trust developed through consistent caring (TLC - tender loving care), laying the groundwork for self-reliance and healthy independence

- opportunities for solicitation - communication and relationships with others in the family, at school, work, or social activities, etc., will largely determine how we see ourselves and how we develop as unique personalities. Without such relationships, the human personality will not develop.

Part 2: Unmet Needs

Introduce the next topic about what happens when basic needs are not met. (See Exercises 2 and 3.)

The degree to which basic needs are successfully met at any age or or stage in the life cycle determines future functioning. Individuals are affected adversely whenever basic needs are not met. They are said to be in stress. Stress may be physical, emotional, mental, social or a combination of these. Everyone will react differently but some common reactions to stress when basic needs are not met are:

- fear
- anger
- anxiety
- depression
- aggression
- regression
- discouragement
- physical ailments

Part 3: The Family

This section explores the role of the family in meeting human needs.

In earliest times families met all of their own needs, and they still do in some primitive societies. They made their own tools, hunted or fished for their food, cleared the land, sowed and harvested their crops, taught their children as they had been taught, and had their own system for rewards and punishment.

Society as we know it is much more complex. Our society is made up of systems or institutions designed to meet many of the social and physical needs formerly met by the family. This includes schools, banks, shops, laws and the courts, hospitals and health care systems, churches, and the political structure of the federal and state governments. Yet the family remains the primary unit of society and the most important of all social institutions. This is true whether the family is a small nuclear family encompassing all degrees of kinship—siblings, grandparents, aunts and uncles—or the single-parent family.

The family is important to its own members and to society because it has primary responsibility for reproduction, care and nurturing of children, especially in the early years. It is the place where needs for affection, acceptance, security, trust and socialization are first met. It is the transmitter of our cultural heritage - our ancestry, traditions, values and attitudes.

Families provide and select community leaders, finance community activities, staff community enterprises as paid employees or as volunteers, buy the goods and use the services that keep the community prosperous and rear the children who shape its future.

Families are bound together by blood ties, common interests, loyalities and affection. A threat to the stability of the family is a threat to the security and well-being of its members. Because communities are made up of families, a threat to family life is also a threat to community life.

The stability of the family is disrupted when there are disturbances in family relationships caused by such situations as marital incompatibility, financial insecurity, illness and disability, alcoholism and death. Often abuse and neglect of family members is a result of physical or emotional violence between husband and wife, or other adults in the family, or parents and children. There is a growing awareness of how homemaker-home health aide services can help reduce the stress in family life that causes abuse, especially of children but also of the elderly. Neglect of family members often occurs when stress is evident. Neglect implies a failure to provide for basic physical and emotional needs. Frequently such neglect is temporary. However, if the problem is deep-seated, the homemaker-home health aide may be assigned to help Frequently this is so because the mother seems unable to take on responsibility for the care of the children, or because resources are expended for purposes other than to meet basic needs.

Social, economic and cultural factors may result in deprivation and isolation of the family from the total community. Sometimes this will involve a group of families or a community within the larger community. Separation because of cultural, ethnic or other differences may serve to deprive those families or groups of the resources and services of the community. Such deprivation has been experienced by Mexican-American, Indian and black families in America. These families and families of other ethnic groups therefore may have special needs for support services.

Appreciation for the cultural, religious and ethnic differences of people is important for all staff involved in human services. It is especially important for the homemaker-home health aide who spends so many hours in the intimate home situation.

Therefore, where ethnic differences exist in the community to be served, as much information as possible related to life styles should be garnered and provided to the homemaker-home health aides working with these families. The trainees themselves are often a source of valuable knowledge and personal experience. Leaders from the various cultural groups may be asked to participate in the training and present information pertinent to the work of the homemaker-home health aides.

It is because of the importance of the family and of stable home life that homemaker-home health aide services exist. They are specifically intended to protect, maintain and restore family stability in times of crisis or special need and to promote the individual's and family's sense of well-being and independence.

Part 4: Individual and Family Differences

This topic explores the reasons for individual and family differences.

Each person is unique. Each family is unique. In the family, no two individuals are identical. Being different does not necessarily mean being better or worse. Each variation or difference fulfills a purpose known or, often, unknown, for the individual or for the family.

Individuals are different in:

- interests
- temperament - disposition
- physical and mental capabilities
- ambitions
- likes and dislikes

- physical appearance
- goals and values
- role and status within the family and within the community.

Families are different in a variety of ways:

- goals and values - what is worthwhile and desirable
- customs - family and nationality patterns handed down from one generation to the next
- resources - some barely enough to survive, some comfortable with a bit to spare, others with a great deal
- religious beliefs
- ethnic background and culture
- political beliefs and commitment.

Differences in families manifest themselves in many ways, such as how they raise their children, keep house, handle money, prepare meals, etc. They vary in their values and ideas about marriage, love, country, role of the man and woman in the family, relation of children to parents, in feelings toward kin. Most people tend to socialize with those who think and feel much as they do. This creates a lack of contact or exposure to those who are different and often leads to bias. Such bias is needlessly perpetuated because of lack of understanding. Therefore, it is important that the homemaker-home health aide who will be working intimately with a variety of different families be helped to understand differences in life styles.

Part 5: The Need for Homemaker-Home Health Aide Service

At this point, the instructor may draw conclusions about the role of the homemaker-home health aide service in helping individuals and families to meet their basic needs.

Homemaker-home health aide services are an expansion of a community's concern for individual and family life. All of us need help from others. The kind and amount of help depends on many factors, including the nature and severity of the problem and the resources within the family to cope with the situation. For many individuals and families, homemaker-home health aide service is the logical and often the only service needed. In other situations, homemaker-home health aide service will be one of many community services needed to help the individual or the family to maintain or regain stability.

Use Exercise 4 or 5 to discuss the role of the homemaker-home health aide in meeting human needs.

ASSESSMENT

Respond to the following as a group or individually.

1. What human needs might you be helping to meet as a homemaker-home health aide when you:

   a. Clean the house?

   b. Talk about something that you read in a newspaper?

   c. Put clean sheets on the bed?

   d. Help a family to save money on food purchasing?

   e. Teach someone in the family to help with the housework?

   f. Prepare a meal for small children?

   g. Record intake of food and/or medication for a sick person in the home?

   h. Compliment a small child on getting dressed without assistance?

2. Each family is ________________________________

3. The primary way in which needs are met is through

   ____

   ____

   ____

4. List 4 factors which may result in instability of the family.

   ____

   ____

   ____

   ____

   Social and ethnic factors may deprive the family of

   __________ __________

AIDS

Exercise 1: Basic Human Needs

Exercise 2: Unmet Needs and Stress

Exercise 3: Basic Needs and Reactions

Exercise 4: Film—"Home Fires" or "A Better Answer"

Exercise 5: Need Situations and Homemaker-Home Health Aide Service Activities

Exhibit 1: Basic Human Needs

Discussion Questions 1: Basic Human Needs and the Role of the Homemaker-Home Health Aide

Exercise 1: Basic Human Needs

This exercise is designed to involve the trainees by drawing upon their knowledge and experience about what everyone needs to live, to grow and to be happy.

- Elicit a range of human needs from the trainees. Include physical and psychological needs.

- List on a chalkboard or flipchart as they are stated. Use trainees' words whenever possible.

- Guide discussion of the list relative to family or individual differences and services provided by homemaker-home health aides.

- Guide discussion until all key needs are mentioned. Use list for discussion of individual and/or family differences and services provided by homemaker-home health aides.

Exercise 2: Unmet Needs and Stress

This exercise elicits what happens to individuals when basic needs are not met and explores the role of the homemaker-home health aide and the services provided.

- The list of basic human needs generated for Exercise 1 or a new list provided by the instructor is required.

- Using the list, ask the trainees to specify what happens when a basic human need is not met. For example, if appropriate opportunities for socialization are not available, describe what might occur.

- Discuss the role of the homemaker-home health aide and what the aide needs to know about human needs and stress.

Exercise 3: Basic Needs and Reactions

This exercise explores types of needs, identifies fulfilled and unfulfilled needs, and describes people's reactions in these situations.

- Either provide each trainee with the fill-in-the-blank statements or read to the group the statements below.
- The statements require that you try to imagine that you are the person in each of the situations below. Briefly complete the sentences, telling how you think you would feel.

1) I have just moved into a new town. I do not know anyone; I don't even know where there is a grocery store:

I feel____

2) I just had a nice dinner with all of my family and we had fun together.

I feel____

3) I have had a constant backache for nearly a month.

I feel____

4) I was just offered a job and I've been looking for a job like this one for a long time.

I feel____

5) A friend told something about me that was not true.

I feel____

6) I am elderly and can't hear well. Most people don't bother to talk to me.

I feel____

7) I just got a raise at my job because I am a good worker.

I feel____

8) Today my boss told me that the company didn't have enough business to keep me employed. I'll be out of this job in two weeks.

I feel____

continued:

Exercise 3, cont.:

- For each situation, identify a need that was not being met.
- Poll the trainees about how people might react to each situation. Note differences in the trainee group.
- Through discussion, reinforce acceptability of differences in the ways people meet needs and their reactions to unmet needs.

Exercise 4: Film -- "Homefires" or "A Better Answer"

This exercise uses a film to trigger discussion of the range of situations needing service, the components of service, and the contribution of the homemaker-home health aide.

- The film is introduced, the objectives of the session are outlined and the film is shown.
- The types of situations portrayed, the activities of the homemaker-home health aides, and the elements of service are explored through guided discussion.
- List on a chart or board with three headings:

Situation	Needs	Task

Exercise 5: Need Situations and Homemaker-Home Health Aide Service Activities

A series of potential service situations are briefly provided. The trainees can describe needs and homemaker-home health aide services for each.

- Describe the service situations one at a time.

- The situations are:

  - A mother is hospitalized leaving at home her two children, ages 3 and 5. Her husband works regularly during the day.

  - A working husband and father loses a leg in an accident on the job.

  - A 73-year-old man's wife dies a few days after celebrating their 50th wedding anniversary.

  - A 30-year-old mother of three children ages 2 to 12 can't seem to stretch her monthly AFDC check beyond two weeks. Often there is little food for the children. Mother drinks heavily.

  - A middle-aged professional man has just learned that he has terminal cancer. His wife has never worked. Their two sons are away at college.

- For each, ask the trainee what physical and/or psychological need(s) of the underlined persons are not being met or may need to be met.

- Have the group indicate if homemaker-home health aide services might be needed in each situation. If so, why?

- Elicit from the trainees what specific activities a homemaker-home health aide might do to meet needs of these persons or their families.

Exhibit 1: Basic Human Needs

Physical	Psychological
· Food	· Love
· Clothing	· Affection
· Shelter	· Recognition
· Rest	· Acceptance
· Activity	· Security
· Avoidance of Pain	· Trust
· Escape Danger	· Socialization

Discussion Question 1: Basic Human Needs and the Role of the Homemaker-Home Health Aide

1. What are basic human needs?
2. If an individual's basic needs are not fulfilled, what would be likely to occur?
3. What are types of situations that could require homemaker-home health aide services?
4. Stress is shown in a variety of ways. Describe five.
5. What should a homemaker-home health aide know about stress?
6. What needs do families generally meet for their members?
7. Why are individual differences important?
8. Identify six services that are provided by homemaker-home health aides.

UNIT C: UNDERSTANDING AND WORKING WITH CHILDREN

ESTIMATED TIME: 4 hours

INSTRUCTOR: Pediatric nurse practitioner, pediatrician, or social worker

INTRODUCTION

This unit deals with the welfare of children and the role of the family in their physical, emotional and intellectual development. Situations within families which can affect the fulfillment of needs are considered. Emphasis is placed on the role of the homemaker-home health aide within the family and in caring for children.

EXPECTED OUTCOME

The trainee will be able to:

- identify the basic physical and emotional needs of childhood
- recognize common reactions of children and other family members to illness or stress and how they might be handled
- describe family situations in which homemaker-home health aide service may be helpful
- identify ways in which the homemaker-home health aide can establish and maintain relationships with children and with family members
- distinguish between discipline and punishment and between appropriate and inappropriate discipline
- recognize changes or events in a family that the homemaker-home health aide should report to the supervisor.

MATERIALS/EQUIPMENT

Flipchart or chalkboard.

CONTENT

Part 1: Growth and Development

This topic discusses the physical and emotional needs of children for growth and development.

It is within the family that the child first experiences gratification (or frustration) of his needs and develops his first meaningful relationship with others. Through these early experiences, he begins to learn about himself and about others.

The basic physical and emotional needs of children are the same the world over. These needs are most commonly met within a family structure, but they are not always met fully or satisfactorily by the natural mother and father. *Refer to Exhibit 1.*

To be physically strong and healthy, children require:

- nutritious food
- activity—exercise and tasks appropriate to their age
- fresh air
- protection from danger, injury, and infection.

To be emotionally strong and healthy, children require:

- love and affection
- a sense of security and trust
- discipline—guidance, control, and consistency
- an increasing degree of independence—opportunities for responsibility, freedom to experiment and to make decisions
- intellectual stimulation
- reassurance and encouragement.

Discussion here can focus on how a child's development may be affected when physical or emotional needs are not being met.

Growth is a fluid and continuous process. As is true with everything that grows, each part develops at its own rate and in its own special way—the "ground plan" of living things. This unique pattern of physical and mental growth is the core of individuality. Each physical stage in the process has an emotional and intellectual counterpart as the individual moves through the successive stages of life, ultimately to adulthood and old age. At every stage there are satisfactions, problems, hazards and accomplishments which have implications for the next stage.

The instructor should introduce the stages of development. Both sensorimotor and psychosocial developments should be discussed. They can be placed on a flipchart, or Exhibit 1 may be used.

Some sensory and motor developments (physical) are so intimately related it seems appropriate to refer to the process as sensorimotor development. Normal sensorimotor development occurs in a definite sequence with each new development based on the one that went before. A baby cannot sit alone at six months unless he can control his head. The sequences are overlapping: while a baby masters one stage, he experiments with another. Increasing sensorimotor activity is characterized by breaking up gross movement patterns into finer patterns which allow independent movements—the head may be turned without the whole body. Developments occur from the head downward—head control before leg control and areas closer to the midline of the body are controlled before those toward the periphery—shoulders before finger movements. These sequences of development have implications for holding, feeding and weaning and readiness for sitting, walking and toilet training.*

The psychological development of children begins in infancy. Infancy is usually considered to be from birth to one year. The first year is a period of rapid growth and is considered to be the most significant in psychological development. Primary needs are for food, warmth and sleep. During the first year of life, the child is totally dependent upon the care of others. Physical and emotional well-being are intimately related to each other and to those individuals who meet the infant's primary needs. For example, in having hunger needs met, the infant "senses" love and security; if not met, disinterest and rejection. As eye, ear, and other sensory organs develop, the infant begins to distinguish a world outside himself and experiences the first meaningful relationships with others.

The instructor may distribute Handout 1, Developmental Stages, and use it as appropriate to the various stages. The instructor can elicit anecdotes from the group. These examples or a list of characteristics of each phase can be recorded on a flipchart or board.

The "training period" is usually from the end of the first year to about the third year. Having mastered the ability to walk and to reach for things, the child can now propel himself to objects of interest. He is "into everything" because he is curious about the world about him. He is also developing a sense of self and self-will. He learns the meaning of "no". He is learning about limits—what is permissible and what is not, what pleases others and what does not. The following are some characteristics of children during this period and some tips for handling them.

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[1] Conner, Francis P., Gordon Williamson and John M. Supp. Program Guide for Infants and Toddlers. Columbia Press. New York, NY: pp. 100-101.

The instructor may wish to substitute others or include additional illustrations as teaching points.

Characteristics	Tips for Handling
Is curious about many things, especially things above eye level—will climb up on furniture, pull table covers.	Lifting child up occasionally satisfies curiosity.
Puts practically everything into mouth: pins, buttons, and other small objects.	Small objects should be kept out of reach.
Is more "choosey" about food.	Don't force foods child doesn't like.
Becomes less hungry.	When interest in food lags, assume that child has had enough and remove remaining food.
May be frightened by loud noises, absence of parent, unexpected movement, barking or jumping dogs, a bad dream, etc.	Holding the child and simple explanations are reassuring and add to the child's knowledge.
Is attracted to other children.	Encourage sharing.
Makes noise, pounds and bangs, likes to pile blocks, plays with push-and-pull toys.	Simple toys are best. Keep indoor play area clear for movement; use "noisy" toys out of doors, when possible.
May resist toilet training.	Encourage, but don't force or punish.

The first "love triangle" usually begins at about two or three and lasts for three years. The maturation process for boys and girls is different during this period. By this time the child has developed a strong attachment to both parents, and the child discovers the parents' attachment for each other, which must be shared. (Boys develop an attachment for the mother, while girls become more involved with the father.) There is jealousy of the parent of the opposite sex, while at the same time striving to be like that parent to assure his or her love. The "love triangle" occurs even in the absence of one or both parents through fantasy or through those with whom the child has a parental love relationship. Jealousy is normal and unavoidable as the child moves toward sexual identification and the ability to share love. It is part of growing up. Conscience continues to develop as the child tries to please parents in order to be loved.

Refer to Handout 1.

Some characteristics of children at this age are:

- helps in dressing and undressing himself
- runs errands, up and down stairs—this gives a feeling of importance
- washes hands and face, with supervision
- likes to be with other children; enjoys being silly with friends
- imitates parents and other children
- is full of questions: What? Why? How?
- is imaginative—makes up stories.

Middle childhood, usually from six to twelve years, is a period of exploration of the outside world and a desire to be with and accepted by peers. The child comes to learn who he is in relation to other people. He is embarrassed by a display of affection from parents as he first starts to move away from the close, dependent emotional attachment of earlier years.

The characteristics of this age group may be drawn from the trainees and recorded on a flipchart.

They include:

- enjoyment of group play, teamwork
- giving importance to the ideas and opinions of teachers and selected other adults
- alternating "good" and "bad" behavior
- wanting to dress and act like their friends
- arguing about what is expected
- interest in the difference between sexes; some antagonism between sexes is noticeable in later period
- interested in making and exploring things
- spontaneity of relations with adults may sometimes give place to secretive behavior, reticence, even hostility
- interest in having money; small earnings allow responsibility and some independence in spending
- sudden spurt in growth rate during later period
- some children resist good grooming practices.

Adolescence is usually from thirteen to seventeen. It is a period of rapid change. There is accelerated physical growth as height and weight increase, muscle and bone structures change, sexual characteristics become evident, and sex organs and glands start to funtion. Simultaneously, emotional and psychological changes occur. There are intense conflicting pressures as the adolescent struggles for independence yet wants to be dependent, loves and hates, alternates in interpersonal relationships, and strives for sexual adjustment. The adolescent wants to work out his last childlike dependence on his parents and to achieve good, warm relationships with members of his/her own and opposite sex.

Some characteristics of this period are:

- independence in choice of friends
- sensitivity—emotional outbursts may occur without apparent provocation
- body changes cause uncertainty and possible embarrassment
- increased interest in members of the opposite sex
- heightened intellectual interests and sense of values
- need for privacy and need to withdraw from family.

Key factors in dealing with teenagers are patience, tolerance, good humor, and the ability to listen.

Part 2: The Need for Homemaker-Home Health Aide Services

There are many families with children that may need and could benefit from the service during times of stress or special need. Situations range from stable, orderly families with strong, loving ties, temporarily disrupted by the illness or hospitalization of the mother, to highly disorganized, multiproblem families with meager resources and serious deprivation, often experienced for generations. The following are some types of situations which come to the attention of agencies providing homemaker-home health aide services to families with children.

The instructor may wish to emphasize those most common to the particular agency or to substitute others.

- physical or mental illness of the mother at home or in the hospital, preventing care of the children
- death or desertion of the parent, requiring immediate and long-term planning by the family and the agency
- an ill or developmentally disabled child whose parents need relief from constant care responsibilities

- an inexperienced or overwhelmed parent who needs guidance and instruction in meeting the physical and emotional needs of the children and home management

- real and suspected evidence of child neglect and abuse requiring protection of the child while the parent(s) receive specialized help

- drug abuse and alcoholism on the part of either parent.

In all these situations, the goals for service to families with children are generally to:

- facilitate diagnosis, treatment or rehabilitation of the parent or a family member

- enable children to remain at home

- enable children to return to their own homes from foster care or institutional placements

- protect children from neglect or abuse

- enable a family member to work or to receive training for employment

- improve the level of child care and home management or provide care until long-term plans can be made.

Part 3: Reactions of Children and Family Members to Stress

Children and adults react to stress in a variety of ways. Children of all ages react deeply to any threat to their security. For the infant and young child the withdrawal of the mother or parent figure, for any reason, causes fear, anxiety and confusion. Reactions will be expressed differently among children in the same family and within the same age group. The following typical expressions of fear and anxiety can be anticipated:

- fear of the dark

- nightmares

- change in toilet habits—reverting to soiling and incontinence

- withdrawal—nonverbalized fear and anxiety

- aggressive acting-out behavior

- jealousy toward handicapped or ill sibling who seems to be getting more attention

- rigid obedience and extraordinary efforts to please

- testing and rebellion against established routines—going to or returning from school, bathing and dressing, eating habits, nap and bedtime

- playing off one parent against the other.

In addition to normal fears and anxieties, there are practical considerations which may affect children when parental illness or stress occurs. Ordinary privileges such as trips or special outings may be delayed or cancelled. Financial pressures may mean a change in school plans as well as in other activities. If a family member is ill at home, noise and activities may need to be restricted. Energy previously used to manage family activities is used to cope with illness. Fear and anxiety may become pervasive and previously close relationships become taut and strained.

Part 4: Role of the Homemaker-Home Health Aide in Working with Children and Families in Stress

Children and families in stress may present situations requiring tact and understanding by the homemaker-home health aide.

The role of the homemaker-home health aide will vary in each family situation. It will be determined by the seriousness of the problem, family constellation (ages and number of children, single- or two-parent family, availability of relatives), family patterns and interrelationships and financial resources. The ultimate success of the intervention by the homemaker-home health aide will be dependent upon the readiness and ability of the family to use help, the involvement of the family in the plan of care, and the aide's ability to establish and maintain effective relationships with all family members. This section will focus on techniques to assist the aide in forming relationships, particularly with children.

They include: introductions, maintaining or initiating routines, individualizing, constructive discipline, conformity, mealtime and snacks, sleep requirements, play and exercise, prompt responses, and listening.

Introductions are important and were discussed in the section on communication. The homemaker-home health aide should initiate the introduction to each child, identifying the agency represented, and giving a brief explanation appropriate to the child's age of why she/he is there. Efforts should be made to engage the child in spontaneous conversation.

There are several ways to maintain routines or initiate new ones. If the family has established mealtime and food preferences, nap and bedtimes, play and study times, bath schedules, tasks to be done by the children, these should be maintained to the extent possible. The less change, the more comfortable and secure the children (and parents) will feel. Usually, new routines should not be introduced without the consent of the parent. There are numerous occasions when the involvement of the children will help them feel that they are contributing and helping, such as setting the table, helping to prepare vegetables, sweeping, making their beds, carrying items.

Unless the child indicates readiness and willingness, toilet training should not be continued while the mother is out of the home or when she is seriously ill at home. Unless the plan includes help for an inexperienced mother, toilet training would be started only to guide the mother. In their fear and anxiety, children may well regress to soiling themselves. Recognition of their worry, reassurance and patience will help. Treat each child as an individual. Respect feelings, wishes, recognize efforts, interest and accomplishments.

Discipline is frequently involved when working with children. Discipline prepares children to become "grown up"—to be responsible and reasonable. It should be constructive. Discipline is training and guidance. Good discipline often makes punishment unnecessary. Children have strong, aggressive impulses. They need and want control and guidance in the expression of impulses to assure development of emotional security and to help develop self-control.

Suggestions for the homemaker-home health aide include:

- not playing one child off against another; this causes discouragement, jealousy, and "scapegoating"

- ignore tattling: it is an effort to get attention at someone else's expense; differentiate between tattling and informing when someone is doing something harmful

- encourage and praise; praise is a type of regard; encouragement is given for effort or for improvement, however slight; it doesn't compare the child with other children; it promotes an internal sense of adequacy and worth

- provide choices, and accept the child's decision by giving the child the opportunity to accept the natural consequences of his actions; help the child to accept responsibility for his own behavior; present the choices kindly and in a friendly voice

- use positive suggestions when working with children: "Let's do this ...." Avoid using "no" and "don't" as much as possible

- comfort the child who is hurt or upset—an outstretched hand or touch of a hand often soothes an upset child—insecure perhaps because his mother is away from home; a warm bath may relax an overly tired, fussy child

- make mealtime a happy time, encourage children to eat, but don't force them—like adults, children have "off" days when food is not interesting; make food attractive, but serve plain, simple or favorite dishes; encourage children to help plan and prepare special treats; use common sense about between-meal snacks—no harm if the right kind of food is given at a sensible hour

- recognize that individual requirements for sleep vary

- encourage play and exercise—they are natural parts of childhood: children express themselves through play, and their growing bodies require exercise; opportunities to be with other children promote their social, emotional and mental growth

- answer questions at the time they are asked, and make the answers simple, clear and direct

- listen attentively to children, as effective communication is necessary for satisfying, open relationships among adults and between adults and children; like adults, there are times when children want someone to listen and to understand and accept their feelings; effective listening requires eye contact and a posture that says, "I'm listening to what you are saying and to how you're feeling and to what you mean"; nonverbal communication deserves attention also: a frown, broad smile, or sullen look communicates feelings.

The instructor may use Exercise 1 or a similar activity to cover this material.

There are several approaches to establishing and maintaining relationships with adult family members.

The instructor can introduce this topic, using Exhibit 4. The trainee should be involved in describing when to use and when not to use each approach.

- ground rules established early will help family members and the homemaker-home health aide to know what each can expect from the other—hours, time, duties, who is to do what and when, where to begin and what would be most helpful; family schedules and preferences, school times should be agreed upon and understood by all

- encourage parent(s) in making decisions whenever possible and practical

- encourage parent(s) in family activities—to help with household routines and with children as they are able; this reinforces their position and role in the family

- listen (as with children, above); avoid taking sides with one adult against the other

- remember that all behavior has a meaning and that adults react to family stress each in his own way

- avoid giving false assurances; recognize and accept feelings

- leave personal problems outside the front door

- be nonjudgmental and understanding but firm in problems of alcohol and drug abuse; the supervisor or professional team will provide support and guidance in the situation and arrange for referral—*see Selected References*

- show respect for the family's resources, life style, belongings, and confidence.

The care plan developed by the professional team (see Part 2, Unit C, Section I) will establish goals of services for children and families, including hours and days for service and special activities that apply to child care. The homemaker-home health aide may be assigned to provide needed care in an emergency or crisis until the situation can be assessed and a plan developed. In such circumstances there may be little information, and the observations of the homemaker-home health aide take on added importance. Problems and changes should be reported to the supervisor.

Some important events or changes which should be reported are:

- mother returns from or is admitted to the hospital unexpectedly

- father loses his job or doesn't go to work

- children are ill or not going to school

- an accident occurs

- excessive drinking or suspected drug abuse

- serious shortage of food or clothing

- serious disagreements among family members

ASSESSMENT

Assessment may be based on the degree of qualitative participation in Exercises 1, 2, 3, and 4.

SELECTED REFERENCES

Dinkmeyer, Don, and Gary McKay. Systematic Training for Effective Training. Parent's Handbook. Circle Pines, MN: American Guidance Service, 1976.

Designed for parents, the handbook provides some basic principles of child training and practical STEP method for understanding and dealing effectively with children. Questions, weekly activity assignments and problem situations on behavior and misbehavior, communications and discipline are given. The handbook has been used successfully with groups of foster parents and could be adaptable for further enriching the knowledge and skills of homemaker-home health aides working primarily with children.

Josselyn, Irene. Psychological Development of Children. New York: Family Service Association of America. The Happy Child. New York: Random House, 1952.

Both books contain valuable background and resource material about the growth and development of children as social beings. The first was written primarily for social workers and the second for parents. Psychoanalytic material is presented clearly, in logical sequence, with ample use of relevant examples. Of particular use are the interrelationships between infant and childhood experiences and adult adjustment.

Public Affairs Pamphlets: New York.

Cohen, Pauline. How to Help the Alcoholic. 1976.

Freeses, Arthur. Understanding Stress. 1976.

Hill, Margret. Drug - Use, Misuse, Abuse—Guidance for Families. 1974.

Irwin, Theodore. To Combat Child Abuse and Neglect. 1976.

Lindbeck, Vera. The Woman Alcoholic. 1975.

Saltman, Jules. Marijuana. 1976.

Saltman, Jules. What You Should Know about Drug Abuse. 1977.
(Also available in Spanish.)

Shiller, Alice. Drug Abuse and Your Child. 1976.

Note: Special rates are available for pamphlets ordered in quantity. The above pamphlets about drugs should help clarify for the trainee how drugs are used for health reasons and how people misuse as well as abuse drugs. Local organizations should also be contacted for popular types of publications on child abuse, neglect, alcoholism and drug abuse for additional reading by trainee.

AIDS

Exercise 1: Relationships with Children

Exercise 2: Field Visit to Observe Children

Exercise 3: Field Experience

Exercise 4: Case Presentations

Exhibit 1: Physical and Psychological Needs of Children

Exhibit 2: Development and Stages

Exhibit 3: Establishing or Maintaining Relationships with Children

Handout 1: Developmental Stages

Exercise 1: Relationships with Children

This exercise assists trainees in applying approaches for establishing or maintaining relationships with children.

- Review the psychosocial developmental stages, and ask the trainees to describe experiences in establishing relationships with children of different ages.
- Elicit from the trainees how the various approaches could have been used and why.

Exercise 2: Field Visit to Observe Children

A field visit to a day-care center or preschool to observe several age groups and focus on various levels of development could be a productive learning experience.

- The various stages of development should be presented before the visit.
- The ages and groups of children to be observed should be planned.
- Group discussion of the visit should follow.

Exercise 3: Field Experience

This exercise would assign individual trainees to spend part of a day on selected cases with experienced homemaker-home health aides.

- Upon return to the classroom, have each trainee discuss her understanding of the reasons for the service, what the children were like, what most impressed her about the visit, how the children reacted to the services by the homemaker-home health aide. Did the homemaker-home health aide think that the service was really needed? Why or why not?

Exercise 4: Case Presentations

Actual case situations, services, reactions, and activities of the homemaker-home health aide are the focus of this exercise.

- The case presentations could be made by an experienced homemaker-home health aide and supervisor highlighting family problems which necessitated use of the service, reactions of children and adult members of the family to the problem, how the homemaker-home health aide carries out her role, how the homemaker-home health aide uses the supervisor in the management of the case.
- The possible situations could include:
    - . a case in which there is a developmentally disabled child (see Add-on Module "C" in the Appendix)
    - . a case in which the mother is ill at home and her personal care is part of the homemaker-home health aide's assignment (see Section I)
    - . a case in which the major emphasis is on improvement of child care and homemaking practices (see Section III, Part 2)

Exhibit 1: Physical and Psychological Needs of Children

Physical

- FOOD
- ACTIVITY
- FRESH AIR
- PROTECTION
- SLEEP

Psychological

- LOVE
- SECURITY
- DISCIPLINE
- AUTONOMY
- STIMULATION
- REASSURANCE

Exhibit 2: Development and Stages

PSYCHOMOTOR

PSYCHOSOCIAL

- Infancy
- Training
- Love Triangle
- Middle Childhood
- Adolescence

Exhibit 3: Establishing or Maintaining Relationships with Children

Introduction
Maintaining or Initiating Routines
Individualizing
Constructive Discipline
Comforting
Mealtimes and Snacks
Sleep Requirements
Play and Exercise
Prompt Responses
Listening

Handout 1: Developmental Stages

Stage of Development	Approximate Age Range	Key Characteristic	Notes
Infancy	Birth to one year	Totally Dependent	
Training Period	One to Three	Into Everything "No"	
Etc.			

UNIT D: UNDERSTANDING AND WORKING WITH OLDER ADULTS

ESTIMATED TIME: 4 hours

SUGGESTED INSTRUCTOR: Geriatric nurse practitioner or social worker, public health nurse

INTRODUCTION

As life expectancy is extended and our aging population continues to increase, the need for greatly expanded home care services is clear. This unit considers the dimension of the aging phenomenon, the uniqueness of each elderly person, general characteristics and particular needs. The unit focuses on insights and skills needed by the homemaker-home health aide to work effectively with older persons.

EXPECTED OUTCOME

The trainee will be able to:

- identify reasons for the increase in home care services for older adults
- describe general characteristics, particular needs and problems of older persons
- analyze attitudes and beliefs about older persons
- distinguish between fact and fallacy about the aging process
- demonstrate understanding and sensitivity to individual differences in older persons
- identify attitudes and living habits which promote positive mental and physical health for elderly people
- describe the types of situations in which service may be needed and the contribution of the homemaker-home health aide in helping to meet the needs
- identify community resources and services available to older persons.

MATERIALS/EQUIPMENT

Film and projector.

CONTENT

Part 1: General Facts and Figures

This topic provides the trainee with general concepts about the aging.

Today there are about 23 million persons over 65 in the United States. By the year 2000 there will be over 30 million. One out of every nine persons is 65 years of age or older. About 5%, or a little over one million older persons, live in institutions of one kind or another. About 7 million older persons live alone or with nonrelatives. Chronic health conditions limit 41% of older persons to some extent in their major activity—working or keeping house. There are 145 older women for every 100 older men. Many older women are widows. Most older persons are independent and manage their affairs as they always have.

Aging is universal. Aging is normal. Aging is variable. Aging begins with conception and ends with death. It is a normal process for all living things. People age in their own unique ways. The state of a person's well-being in the later years develops from earlier life patterns of diet, exercise, physical activities, mental attitude, social activities, and efforts to prevent illness.

Reactions to life experience vary with each individual. Age is more a matter of mental and physical aging than it is of chronology. Some people are "old" at 35, others are "young" at 75. It is necessary to recognize that most people draw their picture of being aged and of the aging process from those persons who live around them.

Aged means old. Old age is relative. Age 65 is a legal definition of "aged" for social security benefits and most retirement plans. Reduced benefits can begin at 62. Publicly subsidized housing is available for older persons at age 60. Some nutrition and community service programs are available for people at age 50 or 55. Sometimes we talk of "young-old" as 55 to 75 and "old-old" as after 85. It is the latter group which requires most of the homemaker-home health aide services and which is where the frail elderly are found.

Stereotypes do a great disservice to older persons and to ourselves. Such generalizations frequently affect our relationships with older persons, our perspectives, and our planning and programs. It is important to recognize that though they may be alone, not ALL older persons who live alone feel isolated; though they may be limited in mobility, not ALL older persons who are so limited feel left out; though they may be retired, not ALL older persons feel useless. In fact, many retired persons enjoy life more than ever.

Instructor may use Exhibit 1.

Age does not affect one's capacity to learn. Older people can learn. For some adults the learning pattern may differ. Speed of learning may be slower, but the learning may have a deeper value. Yet all trainees will know older persons whose knowledge and learning outpaces the brightest young people around them.

Older people can change. One of the existing stereotypes is that older people will not change. This persists despite the frequent demand for readjustment on the part of older persons in giving up jobs, in changing their physical environment and their way of life of many years. Managing on reduced income, moving to smaller housing or living with a daughter or son is a change which demands a great capacity for adjustment.

Older people want to remain self-directing. Expressions such as "Older people are just like children" indicate serious misconceptions and are misleading in their oversimplification and overemphasis. On the contrary, the maintenance of self-direction for as long as possible is usually the chief desire of older people and the major factor in their continuing self-respect. It is important to recognize that persons with physical limitations are not necessarily limited in their emotional or intellectual capacities.

The instructor may explore how the trainees think and feel about older persons. The attitude scale, found in Exercise 1, could be used at this time.

The aging process is the next topic. Aging is a gradual process. It varies in time and manner with each individual. The process is more discernible in some people than in others. General characteristics include physical and mental changes and emotional adjustments.

The physical changes may be reflected in general slowing up of the metabolic process, slower reflexes, poor circulation, sensory loss, drier and less sensitive skin, loss of teeth, insecure balance, circulatory changes, and others.

Mental changes may occur primarily as a result of changes in brain tissue and thickening of artery walls. These may result in memory lapses, disorientation and irritability. There is emotional impact. Growing old requires adjustment and adaptation to many age-related crises. Depending on earlier life experiences, these crises may cause mild to severe emotional problems in some older people. The crises include:

- retirement, perhaps before one is ready to stop working
- widowhood and death of friends and associates
- reduced physical strength and endurance
- fears of illness, bodily injury and exploitation
- reduced income
- need to make other living arrangements.

Part 2: How It Feels to be Old

The instructor may pass out Handout 1 and introduce the next topic.

Aging may include a degree of sensory loss for a great many persons. Failing eyesight and loss of hearing may cause behavior that is mistaken for confusion, irritability or inappropriate behavior. Other physical disabilities can cause frustration for both young and old.

The instructor may use either Exercise 2 or Exercise 3 for discussion purposes.

Part 3: Basic Needs of Older Persons

How the needs of the elderly are like and unlike those of other age groups.

Many people who have studied the needs of elderly people as well as the needs of society believe that older persons should be as independent as possible for as long as possible and that remaining in their own homes and in the community, whenever possible, is the wisest choice. Even when chronically ill, they often do well at home with some help.

The basic needs of older people do not vary markedly from those of other age groups. They need:

- a cheerful place to live
- a nutritious diet
- something to do that they enjoy, especially if it is useful
- someone to care.

Elicit from the group their ideas about the basic needs of older people.

The myth that older people do not enjoy or engage in sex has, in many instances, caused others to make living arrangements for them that make it difficult to have the privacy necessary for a meaningful and full life.

Attitudes toward sex, including everything from flirting to sex outside marriage, vary greatly among all people of all ages. There is no consensus in our society today as to what is "right" and "proper" or "wrong" and "improper." What one person views as a friendly expression of caring concern may be interpreted by another as a sexual overture, resulting in misunderstanding and hard feelings.

Case studies are included to help the homemaker-home health aide become sensitive to this area as one that has many facets and will most likely occur in some form during some assignment. Sensitivity to the emotional reactions many people feel in discussing the subject of sex, as well as an awareness of its importance, will be helpful to the instructor. One or more case studies found in Exercises 4, 5, and 6 may be selected.

Part 4: Programs and Services for Older Persons

Knowledge of community resources for older persons will help the homemaker-home health aide within the care plans introduce services and programs to those who may benefit from them. (See Exercise 9, and Handouts 2 and 3.)

Most communities have a directory of services, especially for older persons, with which all agency staff should be familiar. The plan of care will indicate the community services that will be used in each situation. The homemaker-home health aide should be particularly resourceful in this knowledge and use of local resources.

The instructor may refer to Section III, Unit C, relating to community resources.

Part 5: Role of the Homemaker-Home Health Aide in Working with Older People

Most homemaker-home health aides will work with elderly persons and will need to adapt services and ways of caring for them to their specific needs. (See Exercises 6 and 7.)

Homemaker-home health aide services enable many elderly persons to remain in their own home or to return there after a stay in the hospital or exteneded-care facility. The service can be used effectively to:

- assist the older person with personal care and other activities during a period of acute illness or a flare-up of a chronic illness

- maintain or improve the level of functioning of a frail elderly person

- protect from abuse, neglect and exploitation the vulnerable elderly

- provide interim assistance to the older person during the absence or illness of the usual care giver

Many of the same skills and concerns in working with other age groups apply to working with the older person.

The following considerations should be discussed and added to by the trainees. The instructor may place each "consideration" on a flipchart or board.

Special consideration in providing services to the elderly include:

- environmental factors
- physical conditions
- nutrition
- mental status
- emotional needs.

The environmental factor of citical importance to the elderly person is safety. The presence of poor balance and slower reflexes is a basic concern. Hazards may include light cords, scatter rugs, untied shoelaces, waxed floors, and gas burners. The older person can save steps by having a small bag or basket to hold eyeglasses, tissues, etc. Furniture and other belongings should not be moved about but kept where the older person is accustomed to finding them.

Physical changes in the older person are significant in providing care. Because of poor cirulation, the house or room may need to be warmer than one normally prefers; older persons need to wear more clothing to keep warm. Layers of clothing should be encouraged during winter months. Lower body temperature is a common event of the elderly in winter. This may be serious if the temperature is not raised. Because of the cost of heating, the elderly may economize on heat to a dangerous point. The homemaker-home health aide must be concerned about maintaining body temperature in the elderly. Limiting baths conserves body temperature. Spot wash as needed. Frequent bathing may also cause excessive dryness with ensuing itching and discomfort. Lotion adds to comfort. Persons with heart conditions should avoid undue exercise or rushing. To prevent dizziness, promote the habit of standing still with hand on chair or other support for a minute or two after rising from bed or chair—a sudden drop of blood pressure may occur. A comfortable chair, a table nearby to hold frequently used articles and big enough for a glass of water or a snack adds to comfort and independence. Encourage activities and changes in position. Unless bodies and minds are used as fully as possible, mental and physical capacities may be lost.

Encourage the older person to come to the dining table or go to the bathroom for as long as is practical. Help with dressing rather than doing the dressing. Allow the older individual to manage by himself, no matter how slowly he moves.

Nutrition is the key to the prevention and control of many ailments. Proper food eaten regularly not only builds up a person physically but helps to build a better spirit. Older people, especially those alone, may skip proper meals until they become weak and dizzy. Sometimes several small meals a day are better than one or two large ones. For some, the main meal is easier to handle if eaten in the middle of the day. If teeth are poor, soft foods may be indicated to prevent indigestion from improper chewing. Elimination problems may be associated with dietary deficiencies and need for more fluids.

Nutrition of the elderly is considered in depth in Section III, Unit 5.

Deterioration in the mental status may accompany advanced years. A faulty memory may cause an older person to forget an appointment or the time and day the homemaker-home health aide is to come. It is helpful to devise reminder systems. Be willing to listen to "oft-told tales". Reminiscing is sometimes used to review life and resolve problems. Be calm and patient with expressions of irritability. Overlook confused statements.

Explanations should be made slowly, keeping in mind possible hearing loss and slow reactions. The older person may have difficulty with fine movements and failing vision. Adequate lighting, sharp colors and large print are helpful in helping the elderly person read and carry on activities.

Older adults have emotional needs to which the homemaker-home health aide may need to respond. Often these will include the delicate responsibility of helping people who are physically and emotionally dependent to retain whatever capacity they have for independence. In so doing, the living patterns established by the older person should be accepted. Avoid disturbing personal belongings without permission, including magazines, papers and boxes. People may be shy and self-conscious about their infirmities. Show respect for their privacy by knocking before entering the room. Some people need to be encouraged to maintain or to develop a variety of interests. The homemaker-home health aide can be very helpful in expanding a person's interests.

SELECTED REFERENCES

BOOKS:

Butler, R. N. Why Survive? Being Old in America. New York: Harper and Row, 1975.

Comfort, A. A Good Age. New York: Crown Publishers, 1976.

Ernst, M., and H. Shore. Sensitizing People to the Process of Aging: The In-Service Educator's Guide. Denton, Tex.: North Texas State University, 1975. (The Center for Studies in Aging)

Jury, M., and D. Jury. Gramp. New York: Grossman Publishers, 1976.

Rich, T. A., and A. S. Gilmore. Basic Concepts of Aging: A Programmed Manual. Washington, D.C.: U.S. Government Printing Office, n.d. (Department of Health, Education and Welfare Pub. No. (OHD) 74-2074)

Working with Older People, Vol. I: The Practitioner and the Elderly. Washington, D.C.: U.S. Government Printing Office, 1974. (Department of Health, Education and Welfare Pub. No. (HRA) 74-3116)

Working with Older People, Vol. II: Biological, Physiological, and Sociological Aspects of Aging. Washington, D.C.: U.S. Government Printing Office, 1974. (Department of Health, Education and Welfare Pub. No. (HRA) 74-3117)

PAMPHLETS:

Facts and Myths about Aging. Washington, D.C.: National Council Aging, 1976.

Facts about Older Americans, 1977. U.S. Department of Health, Education and Welfare Pub. No. OHD-78-20006.

Growing Old—A Guide for Understanding & Help. American Occupational Therapy Foundation, Inc., 6000 Executive Blvd., Rockville, Md. 20852.

ASSESSMENT

Circle "true" or "false":

T F 1. Some families have two or more generations over 65.

T F 2. Most older persons have few friends and are uninterested in life.

T F 3. Joints that are not used tend to get stiff.

T F 4. Most 60-year-old people have the same physical condition.

T F 5. Because of a decreased sense of touch, the older person can suffer burns.

T F 6. Most older persons no longer enjoy companionship with the opposite sex.

T F 7. More than one out of every 10 persons in the United States is 65 or over.

T F 8. Most men over 65 are married; most women are widowed.

T F 9. Families may be reluctant to accept a new mate for their aged parent.

T F 10. One half of all elderly in the United States are poor.

T F 11. In recent years many older persons have returned to school.

T F 12. Sometimes it is the adult children who have a more difficult time accepting the aging of their elderly parent(s) than the elderly or the grandchildren.

T F 13. 80% of those over 65 live in their own household.

T F 14. Most common illnesses of older adults are chronic; most common illnesses of youth are acute.

T F 15. Touching an older person usually helps him or her to understand what you are saying.

T F 16. Most people's retirement income is half their income before retirement.

T F 17. The normal problem of some loss of sight with old age has no psychological effect on the elderly.

T F 18. By 1985 there will be more than 25 million persons over 65 in the United States.

T F 19. Limited income from pensions and savings is frequently inadequate because of effects of inflation.

T F 20. Most older people have problems getting around.

ANSWERS

Item	Answer	Item	Answer
1	True	11	True
2	False	12	True
3	True	13	True
4	False	14	True
5	True	15	True
6	False	16	False
7	True	17	False
8	True	18	True
9	True	19	True
10	False	20	False

AIDS

Exercise 1: Attitude about Older Persons

Exercise 2: How it Feels to be Old

Exercise 3: Film "Shopping Bag Lady"

Exercise 4: Sexual Attitudes Case Study and Role Play

Exercise 5: Community Programs and Services

Exercise 6: Abuse and Neglect of the Elderly

Exercise 7: Coping with Conflicting Situations
Exercise 8: Community Programs and Services
Exhibit 1: Three Key Factors about Older People

Handout 1: Facts about Older Americans

Handout 2: Some Organizations and Local Services for Older Persons

Handout 3: Government Laws and Programs with Specific Reference to the Elderly

Exercise 1: Attitudes about Older Persons

This exercise is designed to identify common stereotypes and misunderstandings about older people.

- Provide each trainee with an "Attitudes toward the Elderly" opinionnaire, read the directions aloud, and allow 5 to 10 minutes for completion.
- Go over the items with the trainees, asking how they responded, and allowing them to get the group's reactions.
- Select several items for discussion.

ATTITUDES TOWARD THE ELDERLY

Here are statements about old age and the elderly. Indicate your reaction in the columns:	Agree	Disagree	No Opinion
1. Most old people are untidy about their appearance.			
2. Old people are usually cranky, critical, and complaining, and almost always depressed.			
3. Old people tend to worry about financial matters.			
4. It is normal for elderly people to withdraw from society.			
5. Older people are inclined to neglect their health.			
6. Older people prefer to be with people of their own age group.			
7. Older people are better off if they live in retirement centers or communities where they are relieved of responsibilities.			
8. Old people prefer to have social and recreational activities planned for them.			
9. Old people tend to be boring because they live in the past.			
10. Old people are lonely because they do not make the effort to develop friendships.			
11. There are more aged women than there are old men.			
12. The majority of the aged in the U. S. are living on inadequate incomes.			

continued:

continued:

	Agree	Dis-agree	No Opinion
13. Loss of hearing, failing eyesight, arthritis, and poor coordination are common health problems of the aging.			
14. Old people usually let their homes or dwelling units run down and deteriorate, therefore making poor neighbors.			
15. Old people are usually suspicious and mistrusting.			
16. Old age, with all its symptoms, does not noticeably occur until retirement or until a spouse dies.			
17. Most people worry about dying and fear death.			
18. The physical changes brought about by old age - graying hair, baldness, wrinkles, sagging skin - all tend to alienate the elderly from the rest of the population.			
19. Old age can be a time for reflection, tying up loose ends, and making peace with one's self, friends, family and God.			
20. Old age presents no troublesome problems for rich people.			
21. Although vitality may wane, most old people are just as capable of managing their affairs as anyone else.			
22. Old people usually become "quaint characters" or "odd balls."			
23. Older people are better off if they can be waited on and cared for.			
24. Old people tend to be crotchety.			
25. Old people are interesting to be with.			

Exercise 2: How It Feels to be Old

This is a role-play exercise, where one trainee represents a "young" person and one an "elderly" person. The objective is to obtain a better understanding of how it feels to be old.

- Divide the group into pairs. Each pair will role-play simultaneously.

- Assign roles. The older person assumes one or more of the following characteristics:

  a. partially sighted
  b. partially deaf
  c. stiffness and/or use of cane
  d. wheelchair-bound
  e. depression, loneliness

- Have each pair spend a short time together in role-play situations such as shopping, visiting, reading.

- Reverse the roles.

- Discuss feelings, attitudes and behavior, using the following questions and comments to stimulate discussion:

  How did you feel as an elderly person? When you were first assigned that role, did you wish you had the other role? Did you think the other person was understanding, accepting of your problems(s)? What were some of the difficulties you experienced, felt as an elderly person? Were you helped more than you needed to be? Were you talked to as an adult or a child?

  As a younger person, were you comfortable with the older person? Did you feel awkward in helping, conversing? Did you wish you had been assigned to the role of the elderly person? Identify some of the "complaints" you had about how you were treated.

Exercise 3: Film: "Shopping Bag Lady"

This exercise uses a film to trigger discussion.

- View film "Shopping Bag Lady" or one of the many other good films that allow the viewer to "feel" what it's like to be old.

- Discuss how it is to be old.

Exercise 4: Sexual Attitudes Case Study and Role-Play

This exercise focuses on sexual attitudes and the knowledge required for homemaker-home health aides to deal effectively and appropriately with such situations.

- Either read or hand out the brief narrative of the case study:

  Laura Jones and Foster Frederick are both widowed and retired. They had known each other when they were young, and recently met again at a class reunion. Their friendship began where it had left off forty years before. They have visited each other and corresponded with one another. Laura lives with her son and his family. Both her son and his wife work. Laura is technically blind and the family has had a homemaker-home health aide come in for a few hours daily to read to Laura, fix her lunch and help her with her personal affairs. Laura has only her Social Security and a few pieces of furniture that are hers. Foster lives in a small college town, has his own home and a modest retirement income. The two are in love and want to live together. For this to be financially feasible, they prefer not to marry so that Laura will not lose her widow benefits. Laura has tried to discuss the problem with her son and daughter-in-law, but they have not really listened, talking about her relationship with Foster as though it were sexual. The homemaker-home health aide arrives to find Laura asking to be taken to the bus station so that she can go to live with Foster.

- Role-play the above situation, with one person playing Laura and the other the aide. Then add the aide's supervisor, who has been called in, and the son (aged 44), who has come home unexpectedly.

- Guided discussion.

Exercise 5: Sexual Attitudes Case Study

This exercise focuses on sexual attitudes and the knowledge required for aides to deal with such situations effectively and appropriately.

- Either read or hand out the brief narrative of the case study:

  Sarah and John Boston have just had to give up their own house and move in with their daughter and her family because of financial and health reasons. The house has three bedrooms and also has a den with a sofa bed. There are two children, one boy aged eight, and one girl aged 12. The first week the Boston's slept on the sofa bed in the den. Now the daughter wants them each to move in with one of the children, as each of those rooms has two twin beds, and the family uses the den a great deal. Sarah and John do not want to be separated. Though John has severe arthritis in his knees and hands and Sarah has mild heart trouble, they still enjoy a meaningful and active sex life.

- Discuss whether or not this case is unusual: one of a kind or typical?

- If there were a homemaker-home health aide in the case, what should his or her role be?

Exercise 6: Abuse and Neglect of the Elderly

Listed are some types of neglect and abuse which the homemaker-home health aide may have an opportunity to observe while working with the elderly and families.

Trainees should be encouraged to identify other types of abuse they may have been aware of.

How can the homemaker-home health aide become aware of situations and conditions that suggest abuse or neglect that is not clearly evident?

What can be done to prevent neglect and abuse?

Types of Neglect and Abuse:

- the family is too busy to notice that grandpa's dentures do not fit well, so he isn't eating properly and is malnourished
- no one noticed that grandmother's eye sight was getting worse. Proper corrective measures were not taken so she fell and seriously injured herself
- some families may use all the elderly person's money and choose to buy a new TV set instead of a new hearing aid for the elderly person
- children sometimes obtain power of attorney and then sell all the assets of the older person

Exercise 7: Coping with Conflicting Situations

Presented with situation similar to the following, what should the homemaker-home health aide do?

- an older person is very seriously ill, has no will and keeps telling the homemaker-home health aide what he wants done after his death
- an elderly lady is approached by a door-to-door salesman to have the roof, furnace, etc., "evaluated" and then repaired. The homemaker-home health aide feels that it is a con game.
- the family of the elderly person wants the homemaker-home health aide to testify that the person needs protective services

Exercise 7 (continued)

- an elderly couple confides in the homemaker-home health aide that they are unhappy because they have been asked to share a room with a grandchild - the grandmother with a 10-year-old girl and the grandfather with the 14-year-old boy
- the cost of services by the homemaker-home health aide has been assumed by the family. However, the elderly person wants to tip the homemaker-home health aide or give her a present
- the family member of an elderly lady wants to put her in the hsopital to die, but she wants to die at home. She is terminally ill

Exercise 8: Community Programs and Services

This exercise provides suggestions for a variety of learning experiences within community programs or services.

- Have the group or individual trainees select from the following suggestions or from an expanded list that they generate.
- They should visit the agency or program selected and prepare themselves to discuss it in the next session.
- Suggested experiences:
  - . visit a nursing home
  - . visit a day care center
  - . eat lunch with a group at a senior center (Loaves and Fishes, Food and Friends or other program funded through Federal grants)
  - . ride with person who delivers "Meals on Wheels"
  - . accompany visiting nurse or homemaker-home health aide from a local agency
  - . ride with the driver of "Lift Bus" or similar local transportation service for the elderly and handicapped
- Discuss field experiences, focusing on:
  - . physical, psychological. social characteristics noted
  - . problems and feelings which were apparent
  - . role of the care giver and particular service in which the individual homemaker-home health aide participated
  - . the way in which care giver and others related to older persons
  - . one's own feelings during community experience.

Exhibit 1: Three Key Factors About Older People

They Can Change

They Can Learn

They Want to Remain Self-Directing

Handout 1: Facts about Older Americans (update as required)

- Today, there are 23 million persons over 65; by the year 2000, there will be over 30 million.
- One out of every nine persons is 65 years of age or older.
- About 5%, or a little over one million, of older persons live in institutions of one kind or another.
- About seven million older persons live alone or with nonrelatives.
- Chronic health problems limit 41% of older persons in their major activity -- working or keeping house.
- There are 145 older women for every 100 older men.
- Most older men are married. Most older women are widows.

Handout 2: Some Organizations and Local Services for Older Persons

Gray Panthers is an organization of retired persons who are politically active and lobby for the rights of senior citizens.

The Association of Retired Persons has a large membership, lobbies for the rights of senior citizens and provides certain services, such as insurance, and information through its magazine.

Senior Citizen Center

The activities provided depend upon available funding and the desires of persons using the Center. Included are recreational activities, learning experiences and hot lunches. Learning activities may include, ceramics, painting and sketching. Recreation may include games and planned trips.

Senior Day Care Centers provide services for persons not ill enough to be in a nursing home or hospital, but who cannot safely be at home alone.

Volunteer Services by Retired Senior Citizens

RSVP provides volunteer services with no pay except transportation.

Foster Grandparents is a program for older persons who like children. The volunteer work may be done in schools, institutions, etc. It is completely voluntary.

Dial-a-Friend

Some communities have arrangements whereby someone telephones homebound seniors once a day to check on their well-being and give friendly cheer. Seniors may also telephone if they need help.

Your community may have other organizations which you may wish to list. For example, those connected with churches. etc.

Handout 3: Government Laws and Programs with Specific Reference to the Elderly

Many laws are divided into Titles and Sections. Frequently, certain benefits are referred to only by number. This can be confusing. Most of the services for older persons are under two laws: The Social Security Act and the Older Americans Act. Both have several Titles and

Handout 3 (continued)

Sections and are frequently referred to by the Title only.

SOCIAL SECURITY BENEFITS

As originally enacted, Social Security was to provide for the material needs of individuals and families, protecting aged and disabled persons against the expenses of illness that can exhaust their savings, keep families together, and give children the opportunity to grow up in health and security. The most important Titles for the aged person are: II, XVI, XVIII, XIX, and XX.

Title II refers to retirement (old age) survivors and disability insurance which are cash benefits paid under the Social Security Insurance Program.

Title XVI refers to Supplementary Social Security Income (SSI) for the aged, blind and disabled. Eligibility is complicated, depending upon income and other assets.

Title XVIII relates to Medicare which is health insurance administered by Social Security Administration. It has two parts - hospital insurance (Part A) and medical insurance (Part B). Regulations about benefits change from time to time so it is necessary to check on those currently in force. The Medical Insurance requires monthly premiums paid by the person receiving benefits. The instructor may obtain a copy of the Handbook for Beneficiaries from the local Social Security Office.

Title XIX known as Medicaid, makes available grants to states to provide medical assistance to needy families with dependent children, aged, blind and disabled and to help people achieve independence or self-care through rehabilitation and other needed services. The program is administered by states. All medical services, both in-patient and out-patient are provided.

Title XX consists of grants to states for social programs. The state may select its own services, but must include at least three for SSI recipients and one related to protection, self-support or self=sufficiency.

OLDER AMERICANS ACT

Makes grants to states for community service projects, research demonstration and training.

Title III is concerned with state and area agencies on aging and provides for state and community programs. The purpose is to encourage and help state and local communities develop comprehensive and coordinated service systems for older persons.

Handout 3 (continued

Title V provides grants for acquisition, alteration or renovation of multi-purpose senior centers. Grants are on a cost-sharing basis.

Title VII involves the nutrition program for the elderly. A state may request allotments through Title VII by submitting a suitable plan to the Commissioner, receive a grant from which it must allot funds to public or private, nonprofit agencies for carrying out the plan. Those who receive nutrition grants must agree to provide at least one hot meal a day for five or more days a week or any added hot or cold meals it may elect to provide that assures at least one-third of the daily recommended dietary allowance. Meals may be provided at centers or be delivered to the home.

Title IX involves community service employment of older Americans. Its purpose is to promote useful part-time employment for persons 55 years and older.

Domestic Volunteer Service Act of 1973 is to help retired persons do volunteer services in the community. The volunteer should be over sixty years of age and may work in any field. They are not paid a salary, but are reimbursed expenses. Included are the foster grandparent program and Older American Community service programs.

The Housing and Community Development Act provides for the acquisition, construction, reconstruction or installation of public works facilities and site or other improvements, including among other things senior centers and low income housing for the elderly and handicapped.

The elderly are also included in the provision of other laws relating to education, etc.

UNIT E: UNDERSTANDING AND WORKING WITH ILL PERSONS

ESTIMATED TIME: 2 Hours

SUGGESTED INSTRUCTOR: Public health nurse, social worker

INTRODUCTION

Illness and disability threaten the stability of home and family relationships. A knowledge of common reactions to illness and of goals for home care service will help the homemaker-home health aide work more effectively with individuals and family members and with the health care team.

The instructor may prefer to teach this unit in conjunction with Section IV, Practical Skills in Personal Care.

EXPECTED OUTCOME

The trainee will be able to:

- identify the principal goals for working with ill persons
- identify some of the ways individuals and family members may react to illness
- recognize changes in behavior of the individual or family members that require professional assessment or re-evaluation
- recognize the homemaker-home health aide's relationship and responsibility to the person, family members, the agency and the care team.

CONTENT:

Part 1: Services for Ill Persons and Their Families

The need for homemaker-home health aide services in times of illness.

Loss of good health presents so many unsettling problems to the ill person and to family members, that the security of the home and familiar surroundings often is opted for, above any other choice, for care and convalescence. Through the provision of professionally directed home care services, many persons can return home from the hospital sooner than might otherwise be possible. For others, the availability of home care services can prevent or postpone hospital admission or unnecessary placements in nursing homes and other residential facilities. Persons in terminal stages of illness often prefer to be with their families and loved ones in familiar surroundings.

When highly specialized personnel and equipment are not required, care at home should be a valid option. In some communities hospice services are brought to the dying persons in their own homes by a multi-disciplinary team.

Following are some of the principal reasons why home care services may be needed:

- to facilitate hospital discharge of persons who can be cared for at home
- to relieve a family member of the constant care of the sick person, providing opportunities for undisturbed rest or for handling of business matters, or time for diversion or recreation
- to assist an individual living alone with the demands of an incapacitated spouse
- to provide working members of the family with the skilled assistance they need in the care of an ill or aged family member
- to assist the health care team in providing a level of skilled care which family members are unable or unwilling to provide for the ill individual
- to assist with rehabilitative procedures and the use of functional appliances directed toward independent living.

Part 2: Common Reactions to Illness

Some techniques for dealing with the reactions to illness:

Reactions of an individual to illness will vary,depending upon the nature of the illness, the degree of incapacity or disfigurement involved, prior life experience and personality. The age and timing of the illness in relation to other events taking place in a person's life and the kind of relationships with others,will also affect reactions to illness. The response of family members will vary, depending upon the nature and duration of demands caused by the illness and upon the strength and stability of the family unit. For some families, the short-term illness of an active member may represent more of a crisis than the long-term illness in another family which has established patterns for coping with the illness. The reverse may also be true; a family may be motivated by the crisis and readily make whatever adjustments are required while another may slowly disintegrate under the burden. A sensitive and perceptive homemaker-home health aide will be aware of and be able to identify some of the common reactions to illness. The reactions discussed here are:

- denial
- depression
- impatience
- over-dependence

The instructor may refer to Exhibit 1.

Denial is a reaction to illness used by some people. By denying its existence and the meaning it has for them, they attempt to cope with illness. They may resist medical care, advice and the treatment regimen in an attempt to carry on as before. They "block out" diagnosis, prognosis or related limitations. Over-optimism is a form of denial. Denial is a human defense mechanism often found when there is high anxiety about the outcome of an illness or surgical procedure. It sometimes happens that the family's response is such that the patient feels the need to deny the illness.

Depression often accompanies illness. Poor appetite, undue sleeping, disinterest in people and things, and preoccupation with the illness is seen in the depressed individual. Depressed feelings may be expressed in such statements as "not pulling one's load," "not being up to it," "being a burden," and other comments. In some instances, the individual is overly apologetic and overly appreciative. Establishing daily routines, giving recognition for realistic effort and progress, suggesting appropriate activities, encouraging participation in decisions and activities, and listening actively are useful techniques with ill persons who are feeling depressed. These approaches are also helpful to family members.

Impatience takes various forms. Impatience with those who are trying to assist the person; impatience with one's self, one's limitations, impatience with the "miracles of modern medicine" and the length of time it takes for healing to take place. Complaints and other expressions of irritability are almost invariably related to discomfort, pain and unhappiness rather than to the homemaker-home health aide's activities or those of other members of the helping team, including family members. Remaining cheerful and calm while continuing to carry out assigned duties efficiently and thoughtfully would be appropriate responses.

Over-dependence occurs when security is threatened by illness and fear of the future. Gratification derived from the attention and care received may help to restore security and a sense of well-being. Encouragement and recognition wisely handled will usually help in the transition from over-dependence to increasing independence as good health is regained. Family members, in their concern for the ill individual, may encourage over-dependence. The aide should help the family recognize when over-dependence is being encouraged.

Part 3: Goals for the Care of Ill Persons

This topic will explore homemaker-home health aide's general goals in caring for the ill person.

The goal in the case of ill persons is the same as in all homemaker-home health aide services: to help individuals and families return to, or remain, in their own homes for as long as it is safe and practical and for them their choice of care and to help them become as independent as their capacities permit. Within these broadly stated goals fall more specific goals for the homemaker-home health aide who is giving personal care to ill people. *The instructor may show Exhibit 2.*

The first goal is to promote self-care and independence. Achieving this goal is an important challenge to the skillful homemaker-home health aide. In the care of the sick person, the homemaker-home health aide should allow any possible participation on the part of the ill person and encourage him in activities as steps toward improvement and greater independence. Doing for an ill person what he is able to do for himself can create unnecessary dependency that will be difficult to manage when it comes time to terminate the service. The promotion of self-care and independence is best achieved in talking with the person about what it is that he can and cannot do. For example, if an individual initiates activity and is making even slow progress, it is best not to interrupt his attempt with an offer of help. If he shows signs of fatigue, or difficulty with the activity, it may be useful to clarify whether help is needed and what kind of assistance would be welcome. Often persons know what kind of assistance they need. Learning to recognize stated and unstated indications of what persons can and cannot do is an important aspect of home health care.

Assuring safety and comfort is the second goal of personal care. Being alert to ways in which physical strain and home accidents can be avoided protects both the person and the homemaker-home health aide. Correct body mechanics in positioning the person receiving care and also in the homemaker-home health aide will prevent unnecessary physical strain. Often the most simple acts provide comfort, such as bringing a cup of crushed ice to a person with a fever or dry mouth, opening or closing the shades.

Maintaining dignity and self-respect is the third goal of personal care. It is particularly important when working with ill persons. Illness can invoke feelings of loss in the individual and family. In some cases, these feelings stem from inability to perform expected roles and responsibilities or from the loss of a job, etc. Among the ways in which dignity and self-respect can be safeguarded are: respect for privacy, treating the person with age-appropriate behavior, and avoiding talking to another individual about the sick person as if he were not there.

Respect for privacy is important. A person may be unable to leave the room or the house to find privacy or to be alone. Attention should be given to requests for being alone when such discussion is initiated. There also is need to respect the rights of privacy in the intimate details of care, such as dressing, bowel and bladder functions, and eating habits.

The ill person should be treated with age-appropriate behavior. The skillful homemaker-home health aide can relate to individuals in a way that conveys commitment and understanding without using baby talk or treating the adult person as if he were a child. The ninety-year-old matriarch of a family may resent a question such as "Did we have a bowel movement today?" but respond well to a simple direct question, "Did you have a bowel movement today ?"

In some circumstances diapers and bibs may be useful for cleanliness and efficiency in the home care effort. However, it is important to be aware of how such procedures may make the person feel. Acceptance by the person may be related, in part, to whether the procedures are introduced in a matter-of-fact manner as necessary, useful or convenient. The aide should be prepared to handle questions directly and allay any anxiety.

Avoid talking about the ill person to another in his presence as if he wasn't there. Sometimes a visitor may ask for personal information about the person. When the person is able to talk, the sensitive homemaker-home health aide can help the visitor make contact with the person by repeating the question of the visitor, something like, "how are you today, Mr. Jones?" This allows the person to give to others the kind of information he chooses to give about his own health.

When the individual is not able to speak for himself, it may be helpful to give a short, but neutral, response in a friendly manner. An example of such a comment is: "Oh, he's coming along, and how are you?"

Maintaining stability is the fourth goal of personal care. The presence of a homemaker-home health aide contributes much to the restoration or preservation of stability in the home. Usually, the homemaker-home health aide is in the home more frequently and for longer periods of time than are other members of the home care team. In some cases she may be the only helping person coming to the home, other than the occasional brief visits of relatives or friends. Some of the ways in which stability of the home can be maintained are:

- doing one's work in an efficient, cheerful and calm manner
- showing respect for the wishes and living patterns of the individual and family
- being dependable and punctual
- planning a work schedule which meshes with the family's schedule and needs
- being clear about the purpose of the service and the plan of care; knowing what tasks can be performed and communicating these clearly to the family and individual

Part 4: Health Care Tasks

Health care tasks are usually associated with personal care. Personal care services by the homemaker-home health aide consist of two types -- supportive personal care and personal care as part of the medical plan.

Personal care as supportive assistance is involved in maintaining and promoting normal standards of health and hygiene in all families served by homemaker-home health aide service. Some elderly and convalescent persons who are otherwise independent may need occasional assistance with activities of daily living -- bathing, grooming, walking or having meals brought to them until they are able to move about without undue fatigue. Some disabled, ill or generally infirm persons who function independently within the limits of their disabilities may need supportive assistance over an extended period or for their lifetime. Both children and adults may need to be reminded to take prescribed medication or they may need simple modifications of the diet. These personal care tasks are viewed as necessary if a child or adult is to attain or maintain as much self-care management as possible. These services are considered routine for the trained homemaker-home health aide functioning in a professionally directed program with applicable policies and professional supervision. Such services may be supervised by the social worker, home economist or other professionals.

Because the homemaker-home health aide may be the only agency staff person in the home on a consistent basis, the ability to observe and report changes is imperative. The continued safety and appropriateness of tasks performed as supportive assistance will depend on the aide's ability and judgment in reporting changes in behavior to the supervisor. Chronic illness or disability is not static but constantly changing. Some of the changes in a person's condition which should be reported promptly are listed below and discussed again in the last section of this unit:

- sleeping an undue amount
- changes in speech, eating or toilet patterns
- prolonged absence from the home
- refusal to take prescribed medication.

Personal care as part of the medical treatment of an ill or disabled person is always under the direction and technical supervision of an appropriate member of the health profession, usually a registered nurse who is a community health nurse. Under these circumstances, personal care requires that:

- the person is under active medical supervision
- an overall plan of care has been developed
- the social situation is sufficiently acceptable to permit care at home.

As a co-worker with the professional nurse and other members of the health care team, the homemaker-home health aide carries out assigned tasks and activities which are part of a total plan to assist the patient to regain and maintain the highest level of activity possible. Depending upon the needs in the situation, the team may include one or more nurses with various specialties, a social worker, physical, speech or occupational therapist, home economist, dietitian, physician assistants as well as other specialists. Personnel may be employed by the provider agency or be from other community agencies and organizations.

As a member of the home care team, the homemaker-home health aide serves a unique and often crucial role in the effective care and rehabilitation of the sick person. At the same time, the aide's presence in the home and thoughtful assistance provides reassurance, relief and encouragement to the family members. The role in relation to the ill person and to family members involves several factors. As in all cases requiring homemaker-home health aide service, the degree of responsibility, nature and extent of activities will vary in each situation. *(For details regarding the Care Plan see Part Unit C Section I.)*

The ultimate responsibility for service rests with professional members of the home care team. The professional has the immediate responsibility for assessment, development, and implementation of the plan of care, with the homemaker-home health aide an integral part of the plan. Generally accepted guides for the homemaker-home health aide role in helping with the care of ill persons include three primary responsibilities:

- supporting and encouraging the person to follow the prescribed medical program. New personal care services would be initiated only on the approval of the supervising member of the home care team.

- giving no service to which the ill person objects. The objection would be reported to the supervisor at the earliest opportunity.

- performing only those tasks which are considered suitable for the person. Determination of suitability -- appropriateness and safety -- is made by the supervising member of the home care team.

In addition to the personal care, other services for the sick person may include:

- preparation of meals and special diets

- housekeeping

- care of clothing -- washing, ironing and mending

- shopping, paying bills

- accompanying the person on walks and to medical and other appointments

- rearranging work areas

- providing companionship and appropriate recreation

Because the homemaker-home health aide is in the home more frequently and for longer periods of time than other staff, her observations influence the plan of care.

Examples of the observations reported to the team are:

- observing and reporting a physical sign or symptom of change *(detailed in Unit B, Section IV)*

- observing and reporting improved appetite and greater interest in doing more for one's self could indicate progress toward recovery and a planned reduction of service

- noting and reporting serious shortage of goods or necessary equipment for the comfort or care of the ill person. Additional community resources may need to be called upon to help

- observing changes in the family situation that may influence ability to meet the individual's care need -- including attitudes and effect of demands of the ill person on the family members.

The supervisor (or other designated member of the home care team) is always the first resource when problems arise. If asked by the ill person, a family member or other members of the health care team to perform an activity that raises a question, the homemaker-home health aide should either talk it over with the supervisor or ask the individual to discuss it with the supervisor, to clarify the safety and appropriateness of the task to be performed. Examples might be the request by an ill person to have an enema, an injection or some other procedure for which the homemaker-home health aide is not trained or that is not within the policies of the agency.

The homemaker-home health aide does not replace the services of the nurse, social worker or other therapist, but by working in close relationship, performing personal care and other services based on an individual evaluation of the individual's total needs, the aide makes a most valuable contribution to the care and comfort of sick persons and overburdened family members.

SELECTED REFERENCES

Kramer, Charles H. "Thorough, Objective Perception Is What Keeps Care Humane." Modern Nursing Home. 20:23-25, December, 1970

Trager, Brahna. "Home Care: Providing the Right to Stay Home." Hospitals, JAHA 49:93, October 16, 1975.

Trager, Brahna. Home Care Services in the United States: A Report to the Special Senate Committee on Aging, 92nd Congress, 2nd Session. Washington, D.C.: U.S. Government Printing Office, 1972.

Addenda to Standards for Homemaker-Home Health Aide Services, National Council for Homemaker Home Health Aide Services, Inc., 1969 New York, New York pp 7-9.

ASSESSMENT:

1. Name three reasons why individuals may need homemaker-home health aide services when there is illness.

   1.____

   2.____

   3.____

2. Describe three ways in which a person may react to illness.

   1.____

   2.____

   3.____

3. What are the goals in giving personal care to the sick person?

   1.____

   2.____

   3.____

   4.____

4. What are the three principal guides for homemaker-home health aides in providing personal care?

   1.____

   2.____

   3.____

5. Name two ways in which the homemaker-home health aide relates to the health care team.

   1.____

   2.____

ANSWERS:

1. To relieve a family member.

   To assist the individual living alone.

   To assist in rehabilitation procedures.

   To assist the health care team carry out procedures.

2. Denial.

   Depression.

   Over-dependence.

   Impatience.

3. Promotes self-care and independence.

   Assures safety and comfort.

   Maintains dignity, respect and privacy.

   Maintains stability in the home.

4. Supporting and encouraging the person to follow medical supervision.

   Giving no service to which the patient objects.

   Performing only those tasks considered suitable for the sick person, the homemaker-home health aide and the agency (policy).

5. Observing.

   Reporting.

   Carrying out procedures that have been taught.

AIDS

Exercise 1: Reactions to Illness and Stress

Exercise 2: Selected Personal Care Goals; Role Play

Exercise 3: Personal Care Tasks

Exhibit 1: Reactions to Illness

Exhibit 2: Personal Care Goals

Exhibit 3: Role of the Aide in Relation to Selected Factors

Discussion Questions 1: Understanding and Working With Ill Persons

Exercise 1: Reactions to Illness

This exercise is designed to focus discussion and exploration on common reactions to illness. These reactions would include denial, depression, impatience, and dependence.

- Elicit from the trainee group several situations from their experience that exemplify each reaction.
- Explore possible human needs that are involved in the reactions.
- List on a flipchart or board.
- Guide discussion concerning the needs and reactions. Why are needs and reactions important for homemaker-home health aides to recognize and understand?

Exercise 2: Selected Personal Care Goals: Role Play

The goals of personal care are emphasized in this exercise through selected role plays. The personal care goals include: promoting self-care and independence, assuring safety and comfort, maintaining dignity, and maintaining stability.

- Divide the group into pairs.

- Have each pair in turn determine and present a difference hypothetical situation. The role plays should focus on ways to meet each goal.

- Open each situation for discussion by the group.

Exercise 3: Personal Care Tasks

This exercise will identify a variety of personal care tasks performed for ill persons and their families. It will assist in distinguishing between supportive personal care and personal care that is part of a medical plan.

- Ask the group to generate a list of personal care tasks.
- Place them on a chart or board.
- Next, have the group assign the tasks they listed to either of the following:

Supportive	Medical Plan Related

- Guide discussion to point out differences in tasks and the homemaker-home health aide's role.

Exhibit 1: Reactions to Illness

DENIAL

DEPRESSION

IMPATIENCE

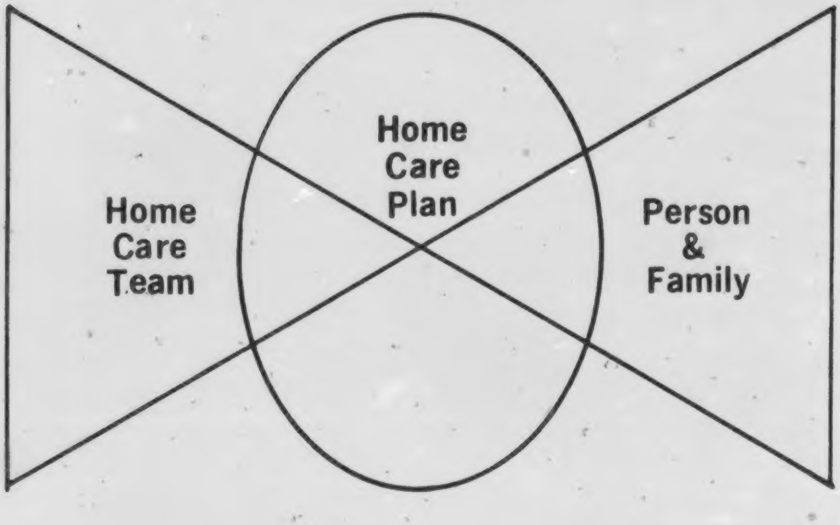
OVER-DEPENDENCE

Exhibit 2: Personal Care Goals

- Promoting Self-Care and Independence
- Assuring Safety and Comfort
- Maintaining Dignity
  - Respect for Privacy
  - Age Appropriate Behavior
  - Avoid Talking as if Patient Isn't There
- Maintaining Stability

Exhibit 3: Role of the Homemaker - Home Health Aide In Relation to Selected Factors

home care team	home care plan	person and family


Home Care Plan
Home Care Team
Person & Family

Discussion Question 1: Understanding and Working with Ill Persons

1. Discuss the reasons why persons may need homemaker-home health aide services.
2. What are some of the feelings that go with being sick?
3. How do you feel about yourself when ill - what kinds of feelings are generated, and how do you deal with them?
4. How do you feel about others when they are sick? Which of the feelings that are generated by illness would you find most difficult to deal with?
5. How can a homemaker-home health aide relate to a sick person without feeling that he is a burden, or feeling sorry for the sick person?
6. Denial is one of the feelings that come with long and short term illness. Give an illustration of how a sick person might act, and discuss how the homemaker-home health aide might respond to it.
7. What are other reactions to illness?
8. Describe the ways in which homemaker-home health aide service assists in the care of ill persons.
9. Describe how a homemaker-home health aide can relate to the ill person and maintain the dignity of the sick person.
10. Describe the team approach and the role of the homemaker-home health aide. Who is on the team? What is the service plan?

UNIT F: UNDERSTANDING AND WORKING WITH DISABLED PERSONS

ESTIMATED TIME: 2 hours

SUGGESTED INSTRUCTOR: Social worker, community nurse or rehabilitation center staff member

INTRODUCTION

Physical and mental handicaps present special problems for coping with activities of daily living. Adults and children with disabilities and their families come to the attention of homemaker-home health aide services. To work effectively with them, the homemaker-home health aide should have some understanding of disabling conditions. Knowledge, techniques and skills for working with specific disabilities should be provided by individual instruction or given in more advanced training sessions. *This unit and the appendix module provide an introduction to working with disabled persons. For in-depth training see the manual for specialized instruction of homemaker-home health aides working with developmental disabilities available from the National Council for Homemaker-Home Health Aide Services Inc., 67 Irving Place, New York, N.Y. 10003.*

EXPECTED OUTCOME

The trainee will be able to;

- distinguish between a disability and an illness
- assess one's own attitude toward persons who are disabled
- know the principal goals for working with disabled persons and their families
- identify some ways disabled persons can be helped to function more independently

CONTENT

Part 1: Disability and Illness

This section distinguishes between disability and illness.

The term disability refers to permanent physical or mental incapacity. It is the absence or impairment of some function - specific activity or skill - that will not return with time. The range of disabling conditions include blindness, deafness, inability to walk, speech disorders, mental retardation and other conditions. A disability may be caused by an accident in which irreversible damage occurs to the brain or to some other organ or part of the body. Complications at the time of conception or during pregnancy and delivery may also result in the birth of a developmentally disabled child. Chronic illness, though often not visible to others, such as diabetes or some heart conditions, might also impair one's ability to perform certain activities or use certain skills.

Illness is the absence of good health - an unhealthy or diseased condition of the body or mind associated with pain and discomfort. While an acute or chronic illness may produce a temporary or permanent disability, a disability does not produce illness, although the disabled person may have a susceptibility to illness.

It is important to remember that disabled or handicapped persons are persons who happen to have a disability. As persons, whether children or adults, they have the same basic needs as everyone else. These needs may be intensified by the particular loss of function, the age, personality structure and the capacity of the individual to make adaptation to his handicap. Reactions to handicapping conditions differ among individuals and within the same individual from time to time.

Since the kind and degree of disability and adaptation vary with each person, tasks performed for or with the individual must be consistent with the amount of functioning the individual can realistically manage for himself. Not everyone with a physical or mental disability needs help, but many do. With instruction, prosthetic devices and ingenuity many disabled persons manage activities of daily living and are gainfully employed. Others require periodic help and still others require assistive help or custodial care throughout their lives. An increasing number of disabled persons are establishing their own homes and living independently.

Families of severly handicapped children are faced with many difficult problems. In addition to the demands on their time and energy in caring for the handicapped child,parents must also cope with their own feelings. Guilt, shame, disappointment, anger and frustration are often present. Family members may resent the time and special care given to the handicapped child and parents themselves may be burdened with guilt for neglecting others. Sometimes their anger and guilt cause parents to reject the child or to deny the painful presence of the condition. Generally efforts are made to help the family maintain the child or person with the developmental disability in his own home in as normal circumstances as possible, but others may need to be in an institution for educational or maintenance care.

Part 2: Goals, Role and the Use of Homemaker-Home Health Aide Service

This topic is concerned with how the special needs of the disabled person and family can be met.

The general goals of the service in working with individuals and families are to:

- promote maximum self-care and independence within the limits of the disabling condition
- provide personal care and home maintenance services for persons who are disabled and living independently
- provide relief to family members by either caring for the handicapped individual or by helping with the care of others in the household
- relieve the parents so that they may enjoy out-of-home activities such as shopping, recreation, vacations, etc.

Techniques and the plan of service are designed for the specific disability, the particular person and the family situation. With additional training, homemaker-home health aides have successfully helped children with handicaps and their parents to establish routines and methods for toilet training, independent feeding, dressing and grooming. Learning to speak was also begun under patient and persistent guidance. Most usually there is a progression of goals with an opportunity for the individual and family to experience success before moving to the next step in self-care. The service can be equally effective in increasing independence of persons with limited sight, mobility and other handicapping conditions. While complete independence may never be achieved by those with severe disabilities, it is possible to help many master enough self-care skills to reduce the burden on others and to become eligible for further specialized training programs. Some of the typical activities which aides can perform to promote self-care and independence (See Handout 1) must be based on careful assessment by professional members of the care team. For added information on Developmental Disabilities, see Appendix 1, C.

SELECTED REFERENCES

Chevigny, Hector. My Eyes Have a Cold Nose, New Haven: Yale University Press, 1946.

A classic first-person account of a writer stricken with total blindness at the height of a successful writing career. An interesting and sensitive book that explains how blind persons can be helped in their efforts to lead as normal an existence as possible.

Rusk, Howard A., M.D., et al. A Manual for Training the Disabled Homemaker. New York: Institute for Physical Medicine and Rehabilitation, New York University, Bellevue Medical Center, 1955.

This manual comes from one of the leading rehabilitation centers in the country and has been edited by one of the pioneers in rehabilitation, Howard Rusk. Many of the suggestions should translate not only to the homemaker but to all with disabilities.

Soyka, Patricia W. "Homemaker-Home Health Aide Services for Handicapped Children," Child Welfare, April, 1976, Volume LV, Number 4. (Available from National Council for Homemaker-Home Health Aide Services, Inc., 67 Irving Place, New York, New York 10003.)

This 11-page article describes reasons for the use of a homemaker-home health aide service in the care of handicapped children. It includes a number of case illustrations of successful service in a variety of different situations. Attention is given to the family and the community. There are references that may be useful for those interested in further reading.

Soyka, Patricia, Thursday's Child Has Far To Go - Help at Home for Children with Special Problems and Their Families, National Council for Homemaker-Home Health Aide Services, Inc., 67 Irving Place, New York, New York 10003.

This book shows how homemaker-home health aide service can provide an extra margin of strength to preserve the home and family when they are confronted by children with special problems.

ASSESSMENT

(Read each statement. Discuss reasons for trainee's response.)

ASSESSMENT OF ATTITUDE	AGREE	DISAGREE	NO OPINION
People with a disability are sick and should be treated the same way ill people are treated.			
Those with disabilities are better off if they are waited on and cared for.			
People who are blind can understand better if people raise their voices when talking to them.			
People with a disability should be treated with pity.			
I feel that people with a disability often can take care of themselves.			

AIDS

Exercise 1: Field Visit to a Rehabilitation Center or home

Exercise 2: Disabled Persons and Their Families

Exercise 3: Disability and Loss

Discussion Questions 1: Disabled Persons

Exercise 1: Field Visit to a Rehabilitation Center or Home

This field activity is suggested to acquaint trainees with the range of handicaps and available services or programs. The visit should be followed by group discussion.

A visit to a home with a physical therapist or a rehabilitation nurse to observe treatment may help demonstrate how complicated treatments can be done in the home.

Exercise 2: Disabled Persons and Their Families

A variety of disabilities will be explored to determine the range of needs, reactions, and services found in each.

- Have the trainees enumerate five types of disabilities.
- Describe the needs of the disabled person and the family in each case situation.
- Discuss how these needs can be met and the factors that might block their fulfillment.
- Discuss the aide's teaching role in the disabilities identified.

Exercise 3: Disability and Loss

Disabilities often mean a loss of one's ability to perform certain activities or use certain skills that were previously unimpaired. When this occurs, a sense of loss and grieving often occurs that is similar to a situation where a death of a loved one has occurred.

- Have the group give examples.
- Discuss the grieving process and working through a loss.
- Indicate the importance of this knowledge for aides.

DISCUSSION QUESTIONS 1: Disabled Persons

1. What is the difference between an illness and a disability?
2. What attitudes are commonly held about disabled? What is their impact?
3. What are the key goals of working with an individual or the family?
4. Specify ways to assist disabled persons increase their independence.
5. Describe the grief process as it applies to disabilities. Give examples.
6. Identify common tasks performed by aides for disabled persons or their families.

UNIT G: MENTAL HEALTH AND MENTAL ILLNESS

ESTIMATED TIME: 2 hours

SUGGESTED INSTRUCTOR: Psychiatrist, mental health nursing consultant, psychiatric social worker or psychologist

INTRODUCTION

This unit considers basic characteristics of good mental health, concepts and common misconceptions about mental illness and the role of the homemaker-home health aide in working with families and individuals when there is mental illness. The care and needs of the mentally ill are considered in more depth in Module C of the Appendix intended for the additional training of the experienced aide.

EXPECTED OUTCOME

The trainee will be able to:

- identify some of the characteristics of good mental health
- describe some of the concepts and misconceptions of mental illness
- describe how the homemaker-home health aide's contribution can be helpful to individuals, families and to the mental health team.

CONTENT

Part 1: Characteristics of Good Mental Health

Good mental health presupposes a sense of self-respect and self-worth. The instructor may elicit from the trainees their concepts of good mental health.

It is evidenced by an individual's ability to:

- give and accept affection and love
- adapt to change
- tolerate varying degrees of anxiety, disappointment and frustration
- accept and handle responsibility for one's decision, feelings and actions

- control desires and impulses until they can be gratified acceptably

- deal with reality in a constructive way

- relate to and live with others in a way that is beneficial to both.

The practical assistance and stabilizing influence of the homemaker-home health aide helps to safeguard the mental health of troubled families and individuals of all ages.

Part 2: Concepts in Mental Illness

Modern concepts of mental illness and their significance are described.

New knowledge in medicine and the social sciences in the 20th century has expanded the view of mental illness. The concept of mental illness has broadened. Rigid lines between mental health and mental illness are no longer recognized. The difference is a matter of degree. Mental illness is an illness like any other but with symptoms different from those to which we are accustomed, such as pain, fever and nausea. Both physical and mental illness are misfortunes but there is no reason to regard one as greater than the other.

It is now recognized that environment, family and interpersonal relationships, particularly in the early years, heredity, isolation and chronic stress have a significant bearing on the incidence of mental illness. Accidents, alcohol and drug abuse, untreated venereal disease, unusually high fever over a period of time, circulatory and other complications which restrict the flow of blood to the brain may also cause mental illness or dysfunction. Mental illness is no longer stigmatized as it has been through the ages although there is still fear and a lack of understanding about it.

Everyone reacts in some way to pressure and stress. These reactions differ with each individual and are not necessarily an indication of mental illness. Symptoms of mental illness differ only in form and degree from those that most of us feel at one time or another -- depression, anger, elation, anxiety, optimism. When a situation becomes too painful, our minds have protective mechanisms for reducing anxiety and stress. Some common defense mechanisms are:

- denial - "just don't believe it."

- depression - "feel terribly unhappy."

- regression - "going back to acting like a child."

- projection - "blaming others."

- rationalization - "trying to explain why over and over."

- aggression - "fighting the world and everybody."

Denial is a method of adaptation in which we refuse to believe that anything is or can be disturbing. Denial may range from a temporary "head in the sand" attitude that operates on the premise that if something is ignored it may go away to complete withdrawal from the world.

Depression is a state of sadness in which the person feels dejected and discouraged. It is an emotional state marked by hopelessness and despair which varies in depth and duration. It is unlike the low feelings everyone experiences from time to time.

Repression is a commonly used tool to put out of the mind feelings and events that are unpleasant and painful. Its use may range from temporarily "forgetting" to do one thing in order to accomplish another, to prolonged repression of thoughts and feelings with ultimate increased anxiety.

Regression is a means of adapting to a situation which an individual feels he cannot handle by reverting to a less mature level of adjustment. By acting less than one's "age" an individual is able to handle a situation or to get others to handle it for him. A toilet-trained child may revert to soiling with the birth of a new baby. An ill adult may revert to the dependency of a small child, allowing himself to relax and enjoy the care given. Regression, like repression, may be used for a brief period as a means of coping with a difficult experience or it may become entrenched into an individual's system of coping with life in general.

Projection sidesteps unacceptable feelings or the consequences of one's actions by placing the blame on others or attributing one's own feelings to others. Projection is a useful but self-deceptive tool that taken to extremes makes one feel that others are "out to get you", and one acts accordingly.

Rationalization places responsibility on circumstances. It explains away one's own behavior as acceptable in order to reduce anxiety caused by unacceptable motives. By rationalizing, an individual can interpret his behavior as having been in the best interests of another or for the good of society when in reality, the act was meant for his own good.

Aggression is striking out at someone or something in an effort to neutralize one's own pain or a threat to one's sense of well-being. Irrational aggression is provoked by frustration, is destructive and usually sudden. Its use may range from compensating for failure in job advancement to an unprovoked physical attack on a passerby.

Other symptoms of mental illness seen in lesser degree in everyone are preoccupation, imaginary illness, sleeplessness, variations in mood, unrealistic fears. Other symptoms go unrecognized for a long period of time not only because they differ in degree from the reactions of most people at one time or another but also because the individual has successfully concealed the symptoms or those about him fail to acknowledge or recognize them.

Treatment

There have been significant advances in the understanding and treatment of individuals with mental illness. These include: awareness that persons with mental illness can be helped just as persons with physical illness can improve or recover with professional help. There has been a movement away from custodial care and confinement in institutions to forms of community-based care such as outpatient departments of general hospitals, mental health clinics, foster homes, day-care programs and congregate living arrangements. The emergence of new forms of treatment and psychotherapy has been accompanied by an increase in mental health professionals such as psychiatrists, psychologists and psychiatric social workers and nurses. The introduction of modern drugs to relieve symptoms has also been an important advance. Despite these advances some misconceptions about mental illness still exist. Because of fear and lack of understanding, some people feel that persons who are mentally ill have lost their minds and will never get better, are not fit for employment or are dangerous. While it is true that some mentally ill persons may and do cause physical harm to themselves or to others, this is not usually the case. Research within the past ten years suggests that spontaneous remission occurs for a percentage of cases in spite of lack of treatment. This is an encouraging finding and consistent with the view that many of those with mental and emotional problems do get better. It is true that during an acute phase of an illness, some individuals are not able to work. Fortunately, for many the acute phase is only temporary, and employment can be resumed. While some return to previous forms of employment, others choose another kind of work that requires different responsibilities and offers greater satisfaction.

Part 3: Role of the Homemaker-Home Health Aide in Situations Where There Is Mental Illness

Explore how the homemaker-home health aide can meet and help mentally ill persons and their families.

The treatment of mental illness requires the combined efforts of a professional team as well as the cooperation of the ill person and the family. As a member of the team, the role of the homemaker-home health aide working with mentally ill persons and their families is not substantially different from the role in other situations requiring the service. Responsibilities will vary depending upon whether the ill person is at home or in a residential facility and will include:

- practical assistance with the day-to-day management of the home

- friendly understanding and reassurance to children and family members

- observing and reporting progress and setbacks in recovery, such as improved or lessened appetite, attention to or neglect of personal appearance, absence or presence of hallucinations, efforts to make or to avoid making decisions. Such observations are valuable to the physician and other members of the team in their plans for the treatment of the person. Observations and reports on the adjustment of family members are of importance.

By understanding that the mentally ill person is a human being in trouble, the homemaker-home health aide's kindness, patience and efficiency can help the mentally ill person to resume his or her normal place in the family or to assume independent living.

SELECTED REFERENCES

Menninger, Karl, with Martin Mayman and Paul Pruyser. The Vital Balance: The Life Process in Mental Health and Illness. New York: A Viking Compass Book, 1963.

The paperback version of this book contains the following:

> "Widely acknowledged as a basic work, The Vital Balance offers a new, unitary concept of mental health and mental illness which dispenses with the old and confusing labels and substitutes a method of diagnosis and treatment in which all disturbed states of the mind and the emotions are seen as stages in a single process. It marks the culmination of a complete revolution in the outlook of psychiatry -- from helpless resignation to active hope and assurance.

For additional references, see Module D in Appendix I.

ASSESSMENT

Assessment of Attitude	Agree	Disagree	No Opinion
1) I feel that mental illness is something that a person has always.			
2) I feel frightened if I know a person has the label of "mentally ill."			
3) I feel that people with mental illness should be locked up and have no business being home.			
4) I feel that a person with mental illness has lost his mind and can not be expected to function again.			
5) I feel that dealing constructively with reality can help promote good mental health.			

AIDS

Exercise 1: Mental Health

Discussion Question 1: Mental Health and Mental Illness

Exercise 1: Mental Health

This exercise focuses on defining a concept of good mental health.

- Ask trainees to list characteristics or behavior associated with good mental health.

- Record on a flipchart or board.

- Guide discussion to cover characteristics and misconceptions.

Discussion Question 1: Mental Health and Mental Illness

What is good mental health? How is it evidenced?

What is mental illness? List the major factors that cause it.

What are defense mechanisms? Describe several.

Name three common misconceptions about mental illness.

Describe the major types of responsibilities homemaker-home health aides have while serving persons with mental illness.

UNIT H: UNDERSTANDING DEATH AND DYING

ESTIMATED TIME: 1 hour

SUGGESTED INSTRUCTOR: Social worker, mental health consultant, physician or clergyman.

INTRODUCTION

The homemaker-home health aide becomes concerned with dying and death when providing services for the aged and for the terminally ill. With the growing interest in hospice care for the terminally ill, the services for the dying at home may increase. Therefore, the trainee should have knowledge about the behavior and feelings of the terminally ill and how these influence the care services and supportive relationship for the family. If the agency is involved in a Hospice Program, a training program of greater depth will be needed.

EXPECTED OUTCOME

The trainees will be able to:

- discuss their own personal feelings about death and dying
- recognize the feelings, reactions and needs of the dying person and family members
- give care to the dying person with an understanding of the person's awareness of impending death, the physical and emotional needs

CONTENT

Part I: Behavior and Feelings About Death

The instructor may wish to use Exercise 1 for discussion of attitudes toward death and dying.

Dying and death is the last phase of the life cycle. Although it is difficult to confront, it requires preparation as do the other stages of life. This should include physical, emotional, social, philosophical and spiritual preparation.

Although death is usually associated with the older person, it may occur at any age. The concepts of death also differ with age. The child is unable to understand death until the pre-adolescent period; the time when the child becomes more concerned with other people. The young child's fears and concerns about death may be manifested through games or concern for pets and the loss of family members. Children may realize their impending death when a long-term illness is present. Studies have shown that they know, despite parental efforts to keep this knowledge from them.

Adult attitudes toward death and dying are influenced by background, culture and religion. Attitudes also differ whether death is sudden or anticipated. Death may have many different meanings for the adult or elderly person facing death because of long illness.

There is no time to prepare for death when it comes accidentally or swiftly, but most persons who approach death because of advanced age or from a terminal illness go through a sequence of feelings and behavior.

In some instances, the person is not told about the seriousness of his condition. This happens because the family does not want him to know or the health team believes that the person could not tolerate or accept the knowledge. This denies the person an opportunity to resolve his own feelings and to direct his energies toward preparation for death. Usually, despite all efforts to conceal the real prognosis of an illness, the person does become aware of the situation. When the person is at home, the homemaker-home health aide respects the wishes of the family and follows the instructions of the plan of care. The observations of the homemaker-home health aide may support the family's and the care team's decision to share the knowledge of the ill person's condition with him.

According to Kubler-Ross, the person and family go through a sequence of reactions: These are denial, anger, bargaining, depression and acceptance.

- Denial and isolation are the first reactions of a person who learns that he is terminally ill. The person is denying when he talks about the future and avoids talking about his illness. Gradually he does begin to face the possibility of death

- Anger occurs when the person recognizes the reality of the course of illness and is angry that he is dying while others are allowed to live. "Why me" is his question

- The "bargaining" reaction is when the person or those around him make promises God to do something special or change their lives if the life can be spared. In some instances bargaining may be life-extending and account for the remissions sometimes seen in terminally ill persons

- Depression occurs when the person becomes weaker and he and those around him are unable to perform even simple tasks because of deep sadness. This is normal. The health team and the homemaker-home health aide need to give physical and emotional help as the person grows weaker. The person may need to express a review of his life and his sorrow. Listening may be most important. Words may not be needed. A touch of the hand and warm accepting silence is therapeutic. Much will depend upon the relationship established earlier. The health team should try to interpret the person's feelings to the family

- Acceptance is the final reaction of the dying person. It comes if the person is given enough time. The person will no longer be angry or depressed having mourned his loss. Depending upon his awareness he can make plans from a religious, philosophical, social and emotional standpoint almost becoming detached

In prolonged illnesses the person and his family may go through all these stages, almost in the sequence outlined. But, more frequently they may revert back and forth to previous stages.

The death of a child is a reversal of life expectancy. The child is often not told that he may die, but may sense it in the discomfort of the parents. The slowly dying child places great demand on parents and those who provide care. The parents and family may need respite services that can be provided by homemaker-home health aide services to ease their conflict over the demands of the ill child and the lack of attention to the other children.

All children, but especially the teenager, facing a lingering death can best be helped by being encouraged to live as fully as possible. Death is not easily accepted at this stage and parents will feel the loss deeply.

For the middle-aged person, death means an interruption of responsibilities to family and career. It brings varied responses, but these are usually concerned with the welfare of the family. Death is expected with advancing age, but the person should be helped to live as long and as fully possible.

Services provided in families where the terminally ill member is the mother of young children require a special concern for the impact on the children during the illness and following death. The homemaker-home health aide's understanding, support and acceptance of the children's feelings of grief helps to keep the home running as normally as possible, and may prevent a serious long-lasting trauma from developing in one or more of the children. In these situations service should frequently be continued until the immediate shock is past and a long-term care plan for the children can be worked out. The agency must be very supportive of the homemaker-home health aide and provide professional help to the family so that clearly it is the team and not just the homemaker-home health aide who helps the family carry the burden.

Part 2: Caring for the Dying

Exercises 2 and 3 may be used as a basis for the discussion of the care and needs of the dying.

In years past, death usually occurred in the home. Now about 70 percent of all deaths occur in hospitals or related institutions. There is growing concern for the dying. There is an increase in books on the subject, seminars and educational programs for health and social workers and others such as the clergy. Concern for the needs and dignity of the dying person is resulting in the development of the hospice movement. Hospice is a term used to indicate special care for the dying. Its aim is to treat the dying person with dignity and to make him or her as physically, mentally, emotionally and spiritually as comfortable as possible. It may be provided in the hospital, a special care facility or at home. The care is given by specially trained people -- doctors, nurses, social workers, psychologists, clergymen -- and may include the homemaker-home health aide when the person is cared for at home.

The Homemaker-Home Health Aide and the Dying Person

Caring for the dying person requires skill and sensitivity as does the support and comfort of family members. In many instances this can be emotionally and physically demanding on those who provide service.

Special concerns for the dying include:

- following plans that are developed for meeting the needs of the person and his family

- providing personal care -- physical care and comfort are a continuing need. Exercise and nutrition are needed to maintain strength

- maintaining routines that should be kept flexible allowing the person to decide when certain care should be given

- modifying procedures to allow for comfort

- explaining to the person what is being done even though the person does not seem to respond

- listening attentively

- protecting the person's privacy and independence

- demonstrating real concern, acceptance and understanding in helping to meet the psychological and emotional needs of the individual and family

- encouraging the family to talk with the person and with each other

Since caring for the dying person is so demanding, it is important that the homemaker-home health aide seek and receive the support of the supervisor and professional team concerned with the person and his family.

Selected References

Beckman, Ruth Murray and Judith Proctor Zenter. Nursing Assessment and Health Promotion Through The Life Span. Englewood Cliffs, New Jersey: Prentice Hall, Inc., 1979, pp.409-432.

Doyle, Nancy. The Dying Person and the Family. 381 Park Avenue South, New York: A Public Affairs Pamphlet, No.485.

Kubler-Ross, Elisabeth. On Death and Dying - What the Family Have To Teach Doctors, Nurses, Clergy and Their Own Families. New York: Macmillan Paper Backs Edition 1970, pp.11-137.

Moore, Florence M. "Homemaker-Home Health Aides - Essential Thanatologists," Home Care - Living With Dying. New York: Columbia University Press, 1979, pp.208-214.

ASSESSMENT UNIT H

1. The attitude toward death and dying may be influenced by:

   ____

   ____

2. The person may not be told he is dying because:

   ____

   ____

   ____

3. When a person dies from a terminal illness or old age, he and his family may go through the following reactions:

   ____________   ____________

   ____________   ____________

   ____________   ____________

4. What is the most important thing to do for a teenager who is dying a lingering death?

   ____

   ____

5. The middle-aged person who is dying may be most concered about:

   ____

   ____

   ____

6. What can a homemaker-home health aide do when a mother of small children is the terminally ill person?

   ____

   ____

7. List five activities that the homemaker-home health aide may perform for the support and comfort of the dying person:

   ____________   ____________

   ____________   ____________

   ____

ANSWERS TO QUESTIONS IN UNIT H

1. Cultural background

2. The family does not want him to know

   The information team believes that the person cannot tolerate the information

3. Denial

   Anger

   Bargaining

   Depression

   Acceptance

4. To live as fully as possible

5. The welfare of the family and making provisions

6. Provide understanding and acceptance of the children's feelings of grief and help in seeing that the activities of the home continue as close to normal as possible

7. Personal care for physical comfort
   Maintain a routine but be flexible
   Modify procedures for comfort
   Be an attentive listener
   Show real concern and acceptance
   Protect the person's privacy

AIDS

Exercise 1: Attitudes Toward Death

Exercise 2: Case Study on Feelings About Death

Exercise 3: Case Study Concerning Death and the Homemaker-Home Health Aide

Discussion Question: Role of the Homemaker-Home Health Aide in Death and Dying

Exercise 1: Attitudes Toward Death [1]

This Exercise is designed to explore attitudes toward death and dying.

- introduce the exercise and distribute the questionnaire
- provide 5 to 10 minutes to respond to the questions
- discuss the group's responses to selected items

There are no right or wrong answers. The purpose of this questionnaire is to help you look at your own feelings about death at this time. Answer as honestly as you can. Feel free to make additional comments on any question in the space marked other. You may mark more than one answer.

1. To the best of your memory, at what age were you first aware of death?

___A. Under age three ___C. Five to ten Other:______________

___B. Three to five ___D. Ten or older ____________________

2. When you were a child, how was death talked about in your family?

___A. Openly

___B. With some discomfort

___C. Only when necessary, and not in front of children

___D. As though death was a forbidden subject

___E. Don't remember any talk about death

3. Which of the following most influenced the way you think about death now?

___A. Death of someone close

___B. Things you have read

___C. Religion

___D. Funerals

___E. TV, movies, radio

___F. Length of time family members have lived, how long-lived

___G. Own health

Other:____

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[1] Occupational Home Economics Education Series, Care and Independent Living Services for the Aging, Section III-A22, Superintendent of Documents, U.S. Government Printing Office, Washington, DC: 1977.

Exercise 1 (continued)

4. Has religion been an important part in the way you think about death?

___A. Very important

___B. Important

___C. Not very important

___D. No part at all

Other:______________________________

5. How often do you think about your own death?

___A. At least once a day

___B. Often

___C. Sometimes

___D. Not more than once a year

___E. Never or almost never

Other:______________________________

6. What does death mean to you?

___A. The end of life

___B. A new beginning, of life after death

___C. Endless sleep and peace

___D. End of physical life, but the spirit lives on

___E. Don't know

Other:______________________________

7. What thing about your own death bothers you most?

___A. I could no longer have any experiences

___B. I am afraid of what might happen to my body after death

___C. I am not sure what will happen to me if there is life after death

___D. I could no longer provide for my family

___E. My relatives and friends would grieve

___F. I could not finish things I had started

___G. The process of dying might be painful

Other:______________________________

____

Exercise 1 (continued)

8. What do you believe causes most deaths?

___A. Most deaths happen because the person wants to die

___B. Most deaths happen because of the way the person uses or fails to use things such as tobacco, alcohol, medicines

___C. Most deaths just happen

9. If your doctor knew that you would die from a disease and had a limited time left to live, would you want him to tell you?

___A. Yes

___B. No

___C. Depends on circumstances

Other:____

10. If it were possible, would you want to know the exact date on which you were going to die?

___A. Yes

___B. No

Other:____

Exercise 2: Case Study on Feelings About Death

This case study allows for discussion of the role and feelings of a trainee in a terminal illness situation.

- introduce case study

- read or hand out the case:

  Henry Wilks, age 88, who lives alone with the assistance of a homemaker-home health aide, learns he has an inoperable cancer and has only a short while to live. He wants to see all of his grandchildren before he dies and so calls the family and begs them all to come to his house for Thanksgiving in two weeks, but doesn't tell them why. They all feel it would be too much trouble for him, and some have other plans. They try to get him to go see his younger brother for Thanksgiving. He is hurt and disappointed and gets angry and hangs up. He then explodes at the homemaker-home health aide, telling her how she wouldn't be there unless he paid her, that no one likes him, and his own children have never really loved him

- discuss the role and feelings of the homemaker-home health aide in this case. How do we react to working for someone who is as seriously ill as Mr. Wilkes? Could anything have been done regarding the Thanksgiving problem? How do you think that you, as the homemaker-home health aide, would react if Mr. Wilkes took his anger out on you

Exercise 3: Case Study Concerning Death and the Homemaker-Home Health Aide

This case study exercise is designed for exploring the role and feelings of a trainee when a death is discovered.

- introduce the exercise to the trainees and establish the learning objectives

- read or hand out the case:

  The homemaker-home health aide and the elderly couple she works for have returned early from their usual morning walk because the man complained of being tired. The man goes into the living room to rest in his favorite chair while the woman goes into the kitchen to put on the kettle for tea and the homemaker-home health aide begins straightening up the bedroom so that the man can lie down. When the tea is ready, the woman goes into the living room to get her husband but returns without him because she doesn't want to waken him from his nap. A little later, the homemaker-home health aide looks into the living room and realizes that the man is probably dead.

- lead discussion of the circumstances of the case. How does the homemaker-home health aide know the man is probably dead? What should be done first? Next? What feelings will the homemaker-home health aide and the man's wife have to struggle with? How can they best cope with their feelings?

- what would the homemaker-home health aide do if she/he arrived at the home to find a person dead who had lived alone? The homemaker-home health aide had been in the home three days before and no one had been there since.

Discussion Questions: Role of the Homemaker-Home Health Aide In Death and Dying

How can the trainee comfort a parent who could not talk about death to the dying child and regrets it later?

How can the trainee prepare for caring for a dying person?

How can the trainee use the supervisor and other professionals for support and help when the demands seem overwhelming?

How would the trainee relate to a family who refuses to allow any mention of "death" to the dying relative?

SECTION III

PRACTICAL KNOWLEDGE AND SKILLS IN HOME MANAGEMENT

Section III includes the first learning units relating to the practical skills that the homemaker-home health aide will use in providing health and social support services in the home. The section consists of three units: "Maintaining a Clean, Safe, and Healthy Environment", "Food and Nutrition", and "Managing Time, Energy, Money and Other Resources".

The extent to which home management skills will be used by the homemaker-home health aide depends upon the program and type of service provided by the agencies. Some agencies introduce the homemaker-home health aide to the service by assignments in home maintenance. Since the homemaker-home health aide functions to meet the needs of individuals and families, responsibilities will vary from minimum care of the immediate environment of the sick individual to total maintenance of the home, care of the children, and preparation of all meals.

It is essential that the homemaker-home health aide understand that working in someone else's home is different from performing the same activities in one's own home. These differences require sensitivity as well as the knowledge that will ensure the safety, protect the health, and conserve the time and energy of both the recipients of service and the homemaker-home health aide.

UNIT A: MAINTAINING A CLEAN, SAFE, AND HEALTHY ENVIRONMENT

ESTIMATED TIME: 6 hours

SUGGESTED INSTRUCTOR: Home economist

INTRODUCTION

Home maintenance and housekeeping may become disrupted and disorganized when health and/or social problems are present. In carrying out the plan for the individual or family, the home management function of the homemaker-home health aide is integral to the treatment process. The sick person feels better and improves faster in a clean and safe environment. Infection and accidents are prevented. In instances where the family is unable to maintain the home because of lack of ability or knowledge, the teaching aspect of the service is of primary importance. In those situations emphasis will be on the role of the homemaker-home health aide in helping to solve problems of home maintenance and in assisting the individual and/or family toward increased responsibility and independence.

EXPECTED OUTCOME

The trainee will be able to:

- recognize the importance of a clean and well-maintained home environment to health and safety and its relationship to the plan of care
- identify the appropriate role and task a homemaker-home health aide usually performs
- perform basic cleaning, housekeeping and maintenance tasks
- choose appropriate procedures, equipment, and supplies and improvise when there are limited supplies, equipment, and money resources
- instruct others in the home to assist with housecleaning and maintenance tasks

MATERIALS/EQUIPMENT

Flipchart, soaps, detergents, mops, dust cloths, vacuum cleaner, special cleaners.

Part 1: Contribution of Housekeeping and Maintenance to the Physical and Psychological Well-Being of Individuals and Families

The homemaker-home health aide contributes to the physical and psychological well-being of individuals and families when performing homemaking activities which include cleaning and maintaining an orderly home.

CONTENT

A clean, safe home is important. When homes are not properly maintained, the chance for hazards to the health of family members increases. There is greater chance for accidents, infection and disease to occur and spread. The safety of the family is at risk.

Sometimes housecleaning may be regarded by the trainees (and the professionals) as an unimportant daily routine. However, it must be recognized as a critical part of the care plan. A clean, well-maintained home enhances the safety, comfort and contentment of its residents. When illness is present, an orderly, clean home becomes an essential part of health care even as it does in the institutional care of the sick and disabled. It should be so thought of by the homemaker-home health aide.

The instructor should use Exercise 1, Worksheet 1, and may use Discussion Question 1. This topic covers the relationship of cleaning and maintenance to the role of the homemaker-home health aide and to the care plan. It stresses the difference in doing housekeeping tasks in one's own home and in that of another person or family. General responsibilities and the usual tasks are discussed.

Part 2: Responsibilities of the Homemaker-Home Health Aide for Maintaining a Clean, Safe and Healthy Environment

CONTENT

A major difference between maintaining a clean, safe and healthy environment in someone else's home and in one's own home, is that responsibilities either contribute to or may be the major goal of the care plan that has been developed by the professional team. Usually the ultimate goal is increased individual and/or family responsibility and independence. Since the homemaker-home health aide will be providing the principle health and social support services in the home, it is essential that the aide be knowledgeable about the purpose of home maintenance activities. The purpose may be to:

- assist the individual or family maintain the environment of the home during illness or because of a disabling condition

- encourage the ill person upon recovery to assume increased appropriate home management responsibilities

- help and teach the disorganized family to solve problems of home maintenance that are due to lack of skills or knowledge

- maintain the home during a family crisis, such as death, desertion, or hospitalization of parent or a child-abuse or neglect situation

The tasks will vary from the care of the sick person's room to general cleaning, including activities such as dusting, straightening, floor care such as vacuuming or sweeping, and washing dishes. Tasks may include cleaning the bathroom and kitchen (refrigerators and ovens) and doing laundry. The specific duties to be performed are outlined in the care plan prepared by the supervisor or care team.

The plan may indicate days for performing specific tasks or it may only indicate the kinds of things to be done, with the homemaker-home health aide being responsible for scheduling activities.

The plan guides the homemaker-home health aide. When problems arise about housecleaning and home maintenance tasks, such as regularly being asked to do tasks not listed on the plan of work or frequent complaints about how tasks are done, the supervisor should be contacted.

Exercise 1 may be used for discussion, or a plan such as Handout in Section I. The instructor may use Discussion Question 1.

It is of primary importance that the aide be sensitive and respectful of the customs and feelings of the individuals and families served. This may include awareness of such factors as:

- methods of performing tasks; the person may want things done their way which is different from that of the aide

- values and life style relating to home maintenance; it may be very important or unimportant to the person or family

- reluctance to have a stranger handle items of personal significance and value

- sensitivity about being unable to do one's own housework, evident in the elderly or the ill person who is no longer able to maintain the home

- the mother who is threatened by the aide who performs more effectively than she is able to because of illness or another reason

In some instances disorganization of the home may be related to problems that must be solved before progress in improving the home can be made. This can include changes of environment or treatment of a psychiatric condition.

The homemaker-home health aide will work in many kinds of homes. Some will be well equipped and furnished, others will be inadequately equipped. Many of the elderly and handicapped live in small apartments or in one room, where space and materials are limited. Sometimes the homemaker-home health aide will be working with families in the impoverished areas of cities and rural areas. Materials such as bedding and equipment may be limited or even nonexistent. There may be communal bathrooms or in rural areas outdoor toilets. Some of these families will have great need for the demonstration of homemaking skills and teaching. How to improvise equipment and "make do" with materials that are available will be an important skill.

Part 3: Cleaning a House - General Guidelines

Some general aspects of cleaning are discussed in relation to homemaker-home health aide services.

Dusting and straightening, cleaning floors and floor coverings, getting rid of garbage and trash are part of maintaining a clean, safe and healthy environment. To the degree possible, the individual or family members should participate in the tasks performed. Only such cleaning as is acceptable to the individual and family should be done. Improving the home environment must be related to the family's style and values. In maintaining a home certain basic concepts can be helpful to the homemaker-home health aide and to the recipient of services.

The instructor may wish to combine this discussion with Unit C, Part I, of this section.

A written plan is a useful guide until a routine is established, starting with a one-week schedule of tasks to be accomplished each day or on each visit. Priority may need to be given to certain activities at certain times. Therefore flexibility is also important.

The instructor may wish to use Exercise 2 and Handouts 1 and 2.

Safety for the members of the household and for oneself is a primary concern in maintaining a home. The homemaker-home health aide should be concerned with identifying and eliminating safety hazards. Safety reminders will be found relating to various procedures throughout the "Curriculum".

The instructor should use Exercise 3 and Handout 3 as a basis for elicity concepts relating to safety.

Health protection should be a guiding principle for all home maintenance activities. A number of diseases may be transmitted from person to person through improper foodhandling and dishwashing.

These diseases include colds, influenza and gastrointestinal diseases such as diarrhea which frequently occur in families. An unclean bathroom or kitchen is a potential source of infection of various types. Hand-washing before and after performing household tasks, especially after handling soiled or contaminated articles, is a basic principle in disease prevention.

See Exhibit 1, Unit 3, Section IV, Handouts 4 and 5.

Roaches, rats, mice and fleas are common carriers of disease. Their control may be an important contribution to family health and cleanliness.

The instructor may use Discussion Question 3 and Handouts 3 and 5.

The use of good body mechanics in performing home maintenance activities is important in avoiding strains on joints and muscles, avoiding injury and preventing undue fatigue. Body mechanics is the way in which the body moves and maintains balance. Houselceaning and maintenance require a lot of bending, standing, stooping, and lifting. Therefore it is important that correct principles of body mechanics be used.

See Exhibit 3, Handout 6.

The proper use of cleaning products is important in effective cleaning and protecting of surfaces, materials and people.

There are four basic kinds of household cleaning products:

- all-purpose cleaning agents
- soaps and detergents
- cleansers
- specialty cleaners

All purpose cleaning agents are useful for general housecleaning and can be used for many kinds of surfaces, such as counter tops, walls, floors, and baseboards. Soaps and detergents are used for bathing, laundering, and dishwashing. Cleansers are used mostly for scouring and for hard-to-clean areas. Specialty cleaners are used for special tasks and surfaces, such as cleaning glass, metal, ovens, etc.

The instructor may refer to Exhibit 1 and Discussion Question 5 and enlist trainees in providing additional examples of products.

The following cautions should be exercised in using household cleaning products:

- Always read the directions on any product you use, especially products used for the first time

- Use only the amount recommended on the label
- Do not mix products, as some cleaners contain dangerous fumes and gases when mixed
- Follow the steps on the label; rinsing is often required and if not done can damage a surface
- Do not leave cleaners on surfaces more than the recommended time, as this can damage a surface
- Overscrubbing can damage some surfaces

Cleaning Tools and Equipment

The care of the home can be made easier with tools suited to various tasks. Some are especially designed for a particular job, others will serve many purposes. This involves responsibility for the use of expensive equipment. The homemaker-home health aide should exercise care and become familiar with the purpose and use of equipment. Equipment should be kept clean and in its proper place. Vacuum cleaners, in particular, should have their brushes and bags checked frequently. If there is no vacuum cleaner, a corn broom may be used to brush the rug and a whisk broom used on the furniture.

Special Considerations in Cleaning the House

The instructor may use Discussion Question 2 as an introduction. Worksheet 2 may be helpful in terms of what procedures and materials to use in cleaning and for the consideration of how to improvise materials and equipment.

Dusting and Straightening. The homemaker-home health aide may find it helpful to keep the house orderly by straightening frequently. Dusting should be done about once a week or when necessary. It may be needed daily, if a person has an allergy.

Cleaning Floors and Rugs. Washing the floor adds greatly to the feeling of cleanliness and order. Vinyl, asbestos or ceramic tile, linoleum and asphalt or rubber floors may be washed. After removing loose dirt or crumbs, wash the floor with a cloth or mop dipped in warm sudsy water. Do not allow water to remain on the floor. Wet floors may be slippery and are frequently a source of falls and home accidents. When vacuuming rugs, use long strokes and go over repeatedly, back and forth, especially if there is heavy dirt.

Care of the Kitchen. Frequently, the plan of care will include cleaning the kitchen. This is an important activity in protecting the health and safety of the family. The kitchen is frequently the site of home accidents and should be carefully checked for safety hazards. Cleaning materials, frequently used in the kitchen, should be kept separately and out of the reach of children. A clean kitchen can also be important in preventing infections.

Wash dishes in hot soapy water and rinse in hot water. When dealing with infectious diseases or colds, use boiling water for rinsing. The heat kills germs. Air dried dishes are more sanitary. Some homes have automatic dishwashers. A family member may demonstrate how to correctly load and start a specific machine model. Automatic dishwashers save time and because of the high temperature are more sanitary. When using an automatic dishwasher, scrape dishes to remove large food particles. Empty cups and glasses. Dishes or silverware should not be crowded in the dishwasher; cups and glasses should be placed open end down. The following items are usually not washed in the dishwasher: electrical appliances, some plastic ware, wooden articles, articles with wood handles, hand-painted or antique dishes, delicate china, fine glassware, some pots and pans. Use only a dishwasher detergent in the amount recommended on the label.

Hot, sudsy water may be used in cleaning the outside of the stove, the trays and burners. Special cleansers should be used only for the oven and according to directions. Sprinkling detergent on the broiler pan immediately after use will make it easier to clean. Ammonia mixed with sudsy water can be used to clean the oven.

The refrigerator should be wiped out frequently and defrosted when there is about one half-inch of frost. When defrosting, turn the the dial to "off" and keep frozen foods wrapped in newspaper. Two tablespoons of baking soda in one quart of warm water may be used to wipe the inside walls of the refrigerator. Baking soda leaves the refrigerator odor-free. The shelves and trays may be washed in soapy water. Defrosting may be accomplished more quickly by placing pans of hot water in the freezer. Never use a knife to chip off the frost; the freezing unit could be damaged.

Maintaining a Clean and Orderly Bathroom. A clean bathroom is important to the health and safety of the family. When the service is limited to personal care, the bathroom should be left clean and orderly. A clean odor-free bathroom is an important part of improving and demonstrating good home maintenance, hygiene and safety.

The moisture and warmth of the bathroom are conducive to the growth of germs. Mold may grow around the bathtub and shower, especially during the summer. Cleaning the bathroom can often help to eliminate the odors encountered in poorly maintained homes.

Many home accidents occur in the bathroom. All rugs should be non-skid. Puddles of water should be wiped up immediately. Bathtubs and showers should be equipped with grab bars, especially when there are elderly and handicapped persons living in the home.

The entire family must be involved in keeping the bathroom clean. Teaching children to flush the toilet, to pick up and hang up wet towels and rinse the sink after use are ways in which the homemaker-home health aide helps to improve home maintenance.

When cleaning the bathtub, shower stall and sink, a sponge or cloth should be used to scrub the sides, edges and bottom of the bathtub, shower stall and sink. The shower stall is often neglected and can be a good place for germs to grow.

An unclean toilet bowl is unsanitary and can be the source of odors. The inside of the bowl should be scrubbed with a brush and cleaner, care being taken to get under the rim. If it is necessary to use a stronger toilet cleaner, the first should be flushed down to avoid possible chemical reactions.

When cleaning the medicine cabinet, special care should be taken not to disturb the labels. Containers should be replaced in the same place, because often persons expect a bottle to be in one position and do not look at the label.

The bathroom floors should be washed and dried carefully to prevent slipping accidents.

Cleaning and arranging storage areas can be an important function, especially in improving home maintenance.

Good storage means that everything has a place convenient for use. Products that are dangerous should be stored out of the reach of children and where they will not be mistaken by adults.

Items should be stored as closely as possible to where they are used: towels in or near the bathroom, pots and pans near the stove, eating utensils near the dining table. Items should be easily seen, reached or replaced. Canned vegetables should be arranged according to variety, children's clothes at eye level and within reach. Things that are used together should be stored near each other. This can save steps and time when cooking or performing other household tasks. Dishes used daily and stored in two different rooms waste time and energy. If a pan is used almost daily, keep it within easy reach. A popcorn popper can be stored in a less convenient place. Clean storage areas occasionally. Remove items, wipe shelves and drawers with a damp cloth, using a general cleaning agent. When shelves and drawers have liners, these may need to be removed and replaced; some can be wiped with a wet cloth. Areas used for food storage or other frequently used items need to be cleaned frequently.

The individual or family in whose home service is being provided should decide what the storage arrangement will be. If changes are needed, the aide should discuss with the family why changes would help in performing activities.

Part 4: Managing Home Laundry

Hand or machine washing is almost always a part of a homemaker-home health aide's work. Exercises 4 and 5 and Handout 7 of this unit focus on factors involved in laundry, including: Laundry aids and supplies, laundry equipment, laundering tasks such as sorting, spotting, folding, ironing, pressing and putting away.

Part 5: Maintenance of Clothing

Repairing clothing and other home sewing tasks which may be required.

Basic mending or sewing tasks may be part of the job for the homemaker-home health aide working with a family, an older person with limited vision or with persons who may not have the time or ability to keep clothing and household linens in repair. Basic mending tasks include: hemming, sewing on buttons, snaps, hooks; repairing ripped seams; patching.

Demonstrate the basic procedures for mending, including hemming, sewing seams, buttons, snaps, hooks, repairing ripped seams and patching. Members of the class may have sewing skills and make the above demonstrations. Be sure that demonstrator points out the kind of sewing tools and equipment needed for these tasks.

Part 6: Teaching Others in the Home to Assist in or Do Home Maintenance

In some situations, a homemaker-home health aide will be asked to help one or more family members learn to do housekeeping tasks. Members of the family should be prepared to assume the responsibility for home maintenance and care when the service is discontinued.

There is an element of teaching in every homemaker-home health aide assignment. Teaching becomes the principal role when the goals of the plan of care are to help individuals and families learn how to better meet the needs of daily living and to acquire a more responsible or self-sufficient life style. This means involving family members in demonstrations and the performance of homemaking tasks, e.g. cleaning, food preparation, shopping and the wise use of resources. It may mean the adaptation of the environment to enable a handicapped person to live independently or teaching a family member to give personal care.

When the goals of the plan include helping the family members to change their modes of living, such goals will be based on careful professional assessment of the strengths and needs of the individual or family and their usual customs. The assessment determines whether there are strengths to build on and how these may be used. Teaching will be most successful when there is recognition by the family that help is needed and there is a desire to change or improve their pattern of living.

A period of time is usually needed for the homemaker-home health aide to establish a helpful relationship with the mother or other person and to get to know the nature and extent of the problem.

When the homemaker-home health aide is teaching others, there are several points to remember.

See Exhibit 2.

- Teaching should be related to existing family members and cultural patterns. It takes time to learn new habits or ways of doing things.
- Things will not be perfect the first time.
- Limit the amount of teaching at any one time.
- Show and explain how to do the task.
- Break down tasks into simple steps that can be easily learned.
- Answer all questions as best you can. If someone wants to know why a particular product is used, or why a task needs to be done in a certain way, take time to explain.
- Be flexible, but within limits. Try to set a time for doing tasks that is as convenient as possible for family members.
- Compliment a task well done.
- Assist the person who is having difficulty, but do not do it for him.
- Point out how doing the task helps the home look better or the people in it feel better.

The instructor can use Exercises 7 and 8 to provide practice in teaching skills.

If teaching family members is part of the plan worked out by the supervisor, the homemaker-home health aide will need to help the family assume responsibility. First steps would be to determine who can do what:

Tasks Younger Children Can Do

Set and clear table
Pick up things
Help with dishes
Empty small wastebaskets
Dust large surfaces

Things Everyone Can Do

Straighten rooms
Put away own things
Hang up own clothes
Put away own clothes
Rinse tub or shower after use

Tasks Older Children and Adults Can Do

Make beds
Help younger children make beds
Wash dishes
Launder
Clean floors
Dust, straighten
Clean bathroom(s)
Straighten closets
Mend
Clean woodwork
Make small repairs

A written plan is often better in the beginning. Start with a one-week plan. *Such a plan might look like Handout 2.*

SELECTED REFERENCES

A Clean House is Important. Division of Home Economics, Federal Extension Service, U.S. Department of Agriculture.

Bratton, Esther C., Home Management Is .... Boston: Ginn and Company, 1971, pp. 212-222.

Care for Your Carpet. Cooperative Extension Service, New Mexico State University, Las Cruces, N. Mex.

Cleaning Sink, Tub and Toilet, Bulletin HS-3. Cooperative Extension Service, The University of Minnesota, St. Paul, Minn.

Clothing Repairs, Home and Garden Bulletin No. 197. U.S. Department of Agriculture.

Housecleaning Checklist. Boulder, Colo.: HomeCall, Inc., 1977.

How to Make the Most of Your automatic Dishwasher. St. Paul, Minn.: Economics Laboratory, Inc.

Ironing. Division of Home Economics, Federal Extension Service, U.S. Department of Agriculture.

Laundry Supplies and Laundry, Doing the Wash. Florida Cooperative Extension Service, University of Florida, Gainesville, Fla.

Let's Clean House. Cincinnati, Ohio: Proctor and Gamble.

The Way to a Better Home. New York: The Soap and Detergent Association.

Widening Horizons: The Teaching Aspect of Homemaker Service. New York: National Council for Homemaker-Home Health Aide Services, Inc.

ASSESSMENT: UNIT A

1. List three basic concepts that should apply when providing home maintenance services.

   ____

   ____

   ____

2. Some reactions or feelings an individual or family may have toward having a homemaker-home health aide providing services in the home.

   ____

   ____

   ____

3. Home maintenance services by the homemaker-home health aide are always based in a ______________________________. This makes it different from doing similar tasks at home.

4. Home maintenance services could be provided because

   ____

   ____

   ____

5. Check YES or NO opposite the correct body mechanics when doing home maintenance tasks:

   YES_____NO_____Carry object as far from body as possible.

   YES_____NO_____Bend the knees.

   YES_____NO_____Lift from the floor.

   YES_____NO_____Keep shoulders up.

   YES_____NO_____Stand as erect as possible.

6. What is a basic measure for preventing spread of disease?

   ____

Assessment: Unit A (continued)

7. If there are roaches and mice in the home, what could you do to help the family minimize the health hazards?

8. ______________________________ and ________________________ may be the primary activities when the aide is helping a family solve home maintenance problems.

9. List five points to remember when teaching others:

____

____

____

____

____

10. Why is a clean, orderly bathroom important?

ANSWERS TO ASSESSMENT: UNIT A

1. - plan carefully
   - safety
   - prevention of disease and infection
   - proper use of the body
   - proper use of cleaning materials and equipment

2. - dislike having strangers handle things
   - do tasks differently than the aide
   - threatened mother because aide does things more efficiently
   - sensitivity about not being able to perform home maintenance tasks

3. -plan of care or service

4. -illness of an individual
   -helping family solve problems of home maintenance
   -a family crisis

5. -no
   -yes
   -no
   -yes
   -yes

6. -wash hands frequently after completing task and handling soiled articles

7. -replace all caps on bottles
   -keep food in tightly covered containers
   -suggest careful use of pesticides, etc.
   -clean carefully, eliminating crumbs, etc., that attract bugs
   -if there is a vacuum, use it in corners, etc.

8. -teaching and demonstration

9. -be patient
   -don't expect perfection
   -show and tell
   -answer all questions
   -be flexible
   -assist but don't do
   -compliment

10. -moisture can lead to bacterial growth
    -accidents can occur easily in bathrooms

AIDS

Exercise 1: Housekeeping and Maintenance Contribution to Well-Being

Exercise 2: Using a Plan

Exercise 3: Safety and Health Hazards and Their Prevention

Exercise 4: Use of Laundry Products

Exercise 5: Laundry Procedures

Exercise 6: Teaching Family Member—Using Role Play

Exhibit 1: Four Basic Kinds of Cleaning Products

Exhibit 2: Points to Remember in Teaching

Exhibit 3: Some Principles of Body Mechanics

Discussion Questions 1: Responsibilities of the Homemaker-Home Health Aide in Maintaining a Clean and Healthy Environment

Discussion Questions 2: Cleaning a House—General Guidelines

Handout 1: Housekeeping Tasks—Rules of Organization

Handout 2: Sample Work Plan

Handout 3: General Household Safety Check List

Handout 4: Home Maintenance Precautions for Preventing Disease

Handout 5: Disease Carriers and Diseases They Transmit

Handout 6: Body Mechanics in Home Maintenance

Handout 7: Steps to Successful Laundry

Worksheet 1: Physical and Psychological Contributions of Maintenance Tasks

Worksheet 2: Commercial and Improvised Methods of Cleaning

Exercise 1: Housekeeping and Maintenance Contribution to Well-Being

This exercise is designed to focus on the benefits of maintenance or housekeeping tasks to the well-being of the service recipient or family.

- Ask the trainees, going round-robin, for suggestions of how these tasks could contribute to individual or family well-being and basic needs
- List these on a chart or board
- Discuss the implications of the items listed for the individual, family and homemaker-home health aide

Exercise 2: Using A Plan

The purpose of this exercise is to assist the trainee in understanding the role, appropriate activities, and inapporpirate activities for homemaker-home health aides in the housekeeping and maintenance area.

- Ask the trainee group to indicate a range of activities that might be performed
- List their suggestions on a flipchart or board in two columns. One column would be "Appropriate Activities" and the other "Inappropriate Activities"
- Through discussion, help the trainees understand the proper role of the homemaker-home health aide in regard to specific tasks or activities

Exercise 3: Safety and Health Hazards and Their Prevention

Have the class divide into three smaller groups. The first group would discuss the physical causes of accidents; the second group the emotional causes of accidents; the third group the environmental causes of accidents. After information from each group is shared with the class, a list of suggestions and changes the homemaker-home health aides could make to accident-proof the home would be devised. Types of accident should include falls, fires and burns, poisonings, suffocation and choking, electrical and cuts.

Knowing the health hazards that may exist in a home, what could the homemaker-home health aide do to minimize or eliminate these conditions? (To be used after Handouts 4 and 5 have been distributed.)

Exercise 4: Use of Laundry Products

Part 1. Using each word or term listed below only once, circle the products that should be used only in the wash water. Draw a line under the products that should be used only in the final rinse.

detergent
soap
bluing
liquid bleach, diluted
powdered bleach

fabric softener
pine oil and disinfectants
(All Pine, Pine-Sol)
borax products
ammonia

Part 2. Never mix in the same water. Connect one word or term from each list (A and B) until all words and terms are used.

A	B
fabric softener	bleach
fabric softener	bluing
fabric softener	synthetic detergent
fabric softener	detergent
bleach	chlorine bleach
bleach	vinegar
soap	water conditioner
ammonia	no-phosphate detergents
ammonia	starch

Answer Sheet

Part 1. In wash water only:

detergent
soap
liquid bleach, diluted,
powdered bleach
pine oil and disinfectants
(All Pine, Pine-Sol)
borax products
ammonia

In final rinse only:

fabric softener
bluing (Blue White, La France, Little Boy Blue)

Part 2. Never mix in the same water:

fabric softener and detergent
fabric softener and bleach
fabric softener and water conditioner
fabric softener and starch
bleach and bluing
bleach and vinegar
soap and synthetic detergent
ammonia and chlorine bleach
ammonia and no-phosphate detergents

Exercise 5: Laundry Procedures

This provides for a brief review of the key points and procedures that should be followed or covered in instructing others.

- Divide the group up into small groups.

- Provide each with a listing of laundry items such as:

  6 pairs children's light-colored socks
  4 pair nylon stockings
  10 sets underwear (children's, men's, women's)
  8 light-colored shirts and blouses
  2 dark-printed shirts
  1 child's red dress
  5 jeans, 2 heavily soiled
  2 pantsuits
  1 bathroom rug and toilet seat cover
  8 bath towels, handtowels and wash cloths
  4 double-bed-size sheets and pillowcases
  1 blanket
  2 pairs men's trousers
  1 tablecloth with grease and ketchup spots
  5 dishtowels and 5 dishcloths
  4 pairs pajamas
  2 bathrobes

- Ask the groups to discuss how they would accomplish the following tasks: sorting, spotting, folding, ironing, putting away, hand-washing, cleaning products, etc.

- Request each small group to present how they would instruct others concerning these tasks.

Exercise 6: Teaching Family Member—Using Role Play

This exercise will provide the opportunity for trainees to practice teaching household tasks to others.

- Divide into threes.
- There will be three roles: homemaker-home health aide, service recipient, and observer. Roles will alternate.
- Set up a hypothetical family situation and have the roles chosen.
- Additional situations and needs can be generated from the trainees or assigned.
- Discuss approaches and content areas.
- Discuss the three different perspectives represented in the role play.

Cases which might be used for role-playing follow.

Role-play a situation in which the trainee is to teach family members how to do housework. Use the family situation in the following case with members of the class assuming family roles or that of the homemaker-home health aide. Go through the process of setting up a plan. Then change roles. Role-play with the trainee teaching a family member how to do a particular task. Repeat this, using different tasks. Rotate the homemaker-home health aide role among the trainees so that as many as possible get to play the role. Afterwards, discuss what happened when using "Teaching Others To Do Houswork."

No single community service can be considered a panacea for all social ills. The teaching aspect of homemaker-home health aide service needs the support of other community resources and services. It cannot take the place of basic necessities, such as adequate income, health services and decent housing. The story of the K's illustrates the need for an adequate environment before effective teaching can take place:

Mr. and Mrs. K. were about to be charged in court with serious neglect of their five children, ages 8, 7, 6, 5 and 1 year old. The children were poorly clothed and undernourished. The older ones were frequently sent home from school because of foul odors. However, the K's were a close-knit, affectionate family and the parents were heartsick at the thought that their family might be broken up. The social service department worker found that the family's four-room house, with an outside pump their only source of water, was in such poor condition that the family's life could not be improved without a change. Fortunately, a more modern house was found. Mr. K. offered to help the owner fix it up. A homemaker-home health aide helped Mrs. K. sort and dispose of stacks of mostly inappropriate donated clothing which cluttered every corner of the old house. They saved what they could later alter for the children. Household equipment was inventoried and a list of minimum requirements was made, for which special allowances were obtained.

When the new house was ready, the homemaker-home health aide helped the family get settled. Then, when there was an adequate environment in which to live, the homemaker-home health aide began to help Mrs. K. learn basic household routines. Both parents cooperated in the changed pattern of living, including improved hygiene and nutrition. "I always wished we could live like other people," said Mrs. K.

Mr. and Mrs. K. were referred to a family planning service after Mr. K. told the social worker, "Now that we have life going better for this family, we want to be able to do the best we can for the kids we have." The serious-neglect charges were dropped and the family is well on its way to normal functioning.

* * * * * *

Mr. and Mrs. G., an aged couple with no children, struggled for years to manage their tiny income from Social Security benefits. The combination of infirmities brought on by advancing years and their inadequate income resulted in a seriously deteriorated level of living. Underclothes and bed linens were rarely changed, eating habits were poor, health needs were utterly neglected and communication with neighbors and others in the community were all but cut off.

Homemaker-home health aide service was requested from a voluntary agency by a hospital social service department after Mrs. G. had broken a shoulder. The immediate needs created by this crisis were met. Then the social worker and the homemaker-home health aide demonstrated how to plan, shop for and prepare nutritious meals on the couple's limited income. Routines were established that emphasized cleanliness while conserving their limited energies. Good health habits were re-established and medical appointments were made and kept.

As the couple appeared less ill-kempt and "strange" to their neighbors, friendly visiting among them began and one neighbor began taking Mr. and Mrs. G. on weekly shopping trips to the supermarket in her car.

An important factor in enabling this couple to re-achieve the quality of life they had enjoyed in their more vigorous years was the homemaker-home health aide's ability to teach them ways to become more independent, as well as doing helpful things for them. The social worker, meanwhile, helped the couple apply for a monthly supplemental security payment to supplement their meager Social Security benefits.

* * *   * * *

The story of Mr. T. shows how the interest, patience and teaching skills of a homemaker-home health aide reversed the downward trend for an old man who had seemed to be incapable of caring for his own needs properly.

Mr. T., whose wife had died six months earlier, was living on alone in their tiny apartment. His landlord had called the homemaker-home health aide agency because he was concerned that Mr. T. might not be able to manage alone any more. He mentioned in particular the fire hazard of newspapers and magazines all over the apartment and "a very bad smell." Mr. T., a mild and gentle man, was "real pleased" with the idea of having someone come to visit a few hours a week and help him with his apartment and meals.

On her first visit, the homemaker-home health aide found Mr. T. dozing in his chair. The stove was on and the apartment was suffocatingly hot. Mr. T. said he hadn't heard her knock because he is hard of hearing. In addition to mountains of newspapers, the homemaker-home health aide found spoiled or spoiling food. Apparently Mr. T. bought food with food stamps, but didn't use it up.

Mr. T. agreed with good humor to the homemaker-home health aide's suggestions for an "Operation Cleanup," and together they sorted the newspapers and magazines and made an inventory of usable food on hand. Mr. T., himself, called for a truck to pick up the papers.

During her next visit, the homemaker-home health aide taught Mr. T. how to make hot cereal. She told her supervisor that he ate "as though he had never eaten before," when she prepared it for him the first time. Gradually he learned how to make it himself, and watched very carefully each time the homemaker-home health aide showed him a new way to prepare food. She also helped him make out shopping lists to use when he went to the supermarket to get the best use of his money and food stamps. She taught him how to use a torch lighter instead of matches to light his stove, important because he had palsy in his hands.

Little by little, it became apparent that Mr. T. was able to manage his own apartment, keeping it clean and orderly, and to prepare nourishing meals for himself. Interestingly, his hearing also seemed to improve so that he always heard the first knock at the door.

* * *   * * *

Exhibit 1: Four Basic Kinds of Cleaning Products

ALL PURPOSE CLEANING AGENTS

SOAPS AND DETERGENTS

CLEANERS

SPECIALTY CLEANERS

Exhibit 2: Points to Remember in Teaching

Be Patient

Don't Expect Perfection

Show and Tell

Answer All Questions

Be Flexible

Compliment

Assist But Don't Do

Point Out Results

Remember Their Role

Exhibit 3: Some Principles of Body Mechanics

Carry Heavy Objects Close

Bend Your Knees

Push Near the Center

Try to Stand Erect

Avoid Lifting from the Floor

Keep Shoulders Up

Discussion Questions I: Responsibilities of the Homemaker-Home Health Aide in Maintaining a Clean and Healthy Environment

1. What are the purposes of the housecleaning and maintenance plan? Who sets up the plan?

2. What housekeeping tasks would you probably be expected to do as an homemaker-home health aide?

3. What would you do if the family asked you to wash windows and that was not on your plan?

4. From what you have read (or heard), what cleaning tasks would you expect to do as a homemaker-home health aide?

5. What should you do if you are asked to do a task you do not know how to do?

6. What steps should be taken if the individual or family complains about the quality of your work?

7. List five tasks that are not appropriate for a homemaker-home health aide to regularly perform.

8. What is the homemaker-home health aide's role in teaching maintenance or housekeeping tasks? When should you do and when should you instruct?

Discussion Questions 2: Cleaning a House—General Guidelines

1. Name the four basic kinds of cleaning products. Give examples.

2. What is the most important caution in using cleaning products?

3. What does an aide need to know about cleaning equipment? What piece of equipment would you like to know more about?

4. What are the major differences in cleaning and dusting windows, bookcases, walls, bathrooms, and appliances?

5. Describe how to clean a hardwood floor.

6. How should household rubbish be disposed of?

7. How often should dusting and cleaning be done? Be specific.

8. What should you do if there are no general cleaning products available in the home?

9. What cleaning, dusting, or straightening activity do you feel most comfortable about? Least comfortable? Why?

10. Select a room and describe how you would organize or plan cleaning tasks for this room. How would this differ from other rooms? Why?

Handout 1: Housekeeping Tasks—Rules of Organization

I. General Guidelines
  a. Easier to clean if you have a plan—but be flexible.
  b. Not every job has to be done every day: some jobs weekly, others just once in a while.
  c. Don't try to do too many "special" jobs on the same day.
  d. Learn to do each cleaning job the right way (basically, top to bottom except on walls—prevent streaking).
  e. Try out little tricks to make it easiest for you. Take fewer steps, try to reach and bend and stoop as little as possible. When you find the most comfortable way to do a job—and still do it right—that's the best way for you.
  f. Collect all the cleaning supplies and tools you will need for each job. Keep them handy to the place where you are working. Basic set of cleaning tools should include two types:
    1. those necessary to soften and remove soil that has dried and hardened on washable surface (wet mops, pails, toilet brush, sponges),
    2. those necessary for removing dry dirt and dust (vacuum cleaner and attachements, carpet sweeper, dust mop, dust cloths, floor broom, brush and dustpan).
  g. Carry your cleaning supplies in a basket with a handle or in any cart that you can roll. Then they can be transported quickly and easily.

II. Job Scheduling
  A. Daily jobs
    1. Kitchen
      a. dishes
      b. tables and counters
      c. stove top and inside spills
      d. empty trash
      e. sink
      f. sweep floor
    2. Bathroom
      a. empty wastebaskets
      b. wash sinks and toilets
      c. wet-mop floor if necessary
    3. Bedroom
      a. air beds and make them up
      b. put clothes away or into wash
      c. straighten room and empty trash
      d. dry-mop floor
      e. dust furniture and window sills
    4. Living room
      a. tidy up; throw out papers; empty ashtrays and wastebaskets
      b. dry-mop floor
      c. dust furniture and window sills
    5. Dining room
      a. clean up crumbs under and around table
      b. dust furniture and window sills

B. Weekly jobs
  1. Kitchen
    a. Clean out refrigerator and wash inside and outside. Do this day before weekly marketing.
    b. Give stove thorough washing, inside and outside.
    c. Scrub the floor with hot, sudsy water and hot rinse water. Wax if necessary.
  2. Bathroom
    a. Use toilet-bowl cleaner, then scrub toilet bowl with the toilet brush and hot, sudsy water.
    b. Wash the mirrors.
    c. Make sure there is enough soap in each soap dish.
    d. Scrub floor and wax, if necessary.
    e. Launder the bath mat and bathroom rug.
  3. Bedrooms
    a. Open the closet doors, so the clothes can air out.
    b. Put clean sheets and pillow cases on the beds. Change or wash the mattress covers or waterproof pads, if they are soiled.
    c. Vacuum floors or use a slightly damp mop to pick up dust.
    d. Use slightly damp mop to dust bare floors.
    e. Use sponge or cloth squeezed out of sudsy water to wipe fingerprints from walls, woodwork, and light switches.
    f. Dust furniture, light fixtures, lamps, books, and small things.
  5. Dining room
    a. Sweep or vacuum carpet or rug.
    b. Use slightly damp mop to dust bare floors.
    c. Use cloth squeezed out of hot, sudsy water to clean fingerprints off walls, woodwork, and light switches.
    d. Dust the furniture, light fixtures, any open shelves and ornamental china, glassware or silver.

Handout 2: A Sample Work Plan. It may also be used by the homemaker-home health aide in planning activities.

DAY	WHAT TO DO	WHO WILL DO IT
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Handout 3: General Household Safety Check List

(Use a check mark (✓) for safe situations)

1. Are strong banisters or railings placed along each stairway? ____
2. Are stairs, halls, and exits free from clutter? ____
3. Are throw rugs eliminated or fastened down? ____
4. Are electrical cords in good condition? ____
5. Are nightlights placed in the bedroom-bathroom area and in halls? ____
6. Is furniture arranged to allow free movement in heavy traffic areas? ____
7. Is storage space easy to reach in areas where often-used items are stored? ____
8. Are pan handles turned toward the back of the stove? ____
9. Are pot holders used instead of apron corners and dish towels when cooking? ____
10. Are grease and liquids wiped up immediately when spilled? ____
11. Are cleaning fluids, polishes, bleaches, detergents, and all poisons stored separately and clearly marked? ____
12. Are hand grippers installed in the bath tub and shower and at the toilet? ____
13. Are non-slip rubber mats placed in bath tub and shower? ____
14. Is bath or shower temperature checked with hand before showering or bathing? ____
15. Is a first-aid kit available at all times? ____
16. Are medicines clearly labeled when they are for external use only? ____
17. Is just one night's supply of pills taken from the medicine chest and placed at bedside? ____
18. Are prescription medicines discarded when the illness for which they were prescribed is over? ____
19. Is light located within easy bedside reach? ____
20. Are shoes kept well-tied and worn for household activities instead of bedroom slippers? ____
21. Are hazardous tools and firearms kept locked? ____

22. Do you have an escape plan in case of fire, with alternate routes to safety, and does everyone in the home know what to do? ____

Handout 2: A Sample Work Plan. It may also be used by the homemaker-home health aide in planning activities.

DAY	WHAT TO DO	WHO WILL DO IT
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Handout 4: Home Maintenance Precautions for Preventing Disease

- Wash hands frequently: before working in the kitchen and after handling soiled or contaminated materials and after going to the toilet.

- Clean counters, tables and shelves where food is prepared and stored. Food may be contaminated if placed on soiled work areas or in unclean utensils.

- Keep food covered: close cartons and replace covers to prevent infestation by bugs or contamination.

- Garbage disposal: Drain off liquid before putting it in a paper or plastic-lined pail. Roll or wrap garbage in paper and place outside in large, covered can or down the apartment incinerator chute each day. Do not put hard or stringy food in the garbage disposal if there is one.

- Tin cans and bottles should be rinsed out to destroy odors and discourage insects and small animals—rats and mice.

- Wash garbage cans, dirty water pails and trash cans with hot, soapy water.

- Clean all areas of the bathroom carefully, especially around the commode. The warmth and moisture of the bathroom are conducive to the growth of germs.

- Cover the nose and mouth when coughing or sneezing.

- Cover open sores or cuts on the fingers or hands with clean bandages. If these sores are slightly infected, serious infections may be transmitted while handling food.

Handout 5: Disease Carriers and Diseases They Transmit

ROACHES are the most despised and hated of all pests. They live in most parts of the world. These offensive insects transport disease organisms on their legs and bodies and in their digestive tracts. Roaches can carry bacteria which cause diarrhea, cholera, and even polio.

FLEAS are found throughout the world. They are carriers of plague, a fatal disease that killed an estimated 25 million people in Europe during the 14th century. There are several common species, including dog flea, cat flea, and rat flea. Most prefer one type of animal but attack others, including man.

TICKS are found all over the world. They feed entirely on blood. Aside from painful bites, they spread a highly fatal disease known as Rocky Mountain spotted fever, also tularemia, relapsing fever, and other diseases.

MOSQUITOES are known all over the world for their painful, irritating bite. They are carriers of malaria, encephalitis, yellow fever, dengue, and filariasis.

RATS and MICE are perhaps the most notorious disease carriers. They carry jaundice, food poisoning, relapsing fever, rabies, trichinosis, and typhus fever on their feet and in their fur, bloodstream, and digestive tract.

Handout 6: Body Mechanics in Home Maintenance

Points to remember in maintaining good body posture while working:

- Maintain normal spinal curves by keeping the chest up and head erect; tighten the muscles of the abdomen and buttocks.
- Stand with feet comfortably apart, with one foot forward.
- Wear comfortable shoes.
- Bend the knees and not the back when lifting things from the floor or kneeling to pick up light objects. Many people have backaches because they bend their backs when lifting and stooping and so strain back muscles.
- Carry heavy objects close to the body and distribute the weight evenly. Example: when carrying a basket of clothes, hold it directly in front of the body.
- Stand close to the work area. When possible, raise the work area to a comfortable working level so that bending will not be necessary.
- Move heavy objects, e.g., furniture, by pushing, pulling, rolling, using the whole body.
- Avoid lifting heavy objects from the floor. Example: put the clothes basket on a chair before filling it.
- Stand erect when doing tasks like washing dishes. Knees may be slightly bent.
- Keep shoulders up while sitting, standing or walking. Many people tend to slump while doing task that require sitting, standing or walking.

Handout 7: Steps to Successful Laundry

I. Washing
- a. Basic steps to follow for successful laundering results:
  1. Sort clothes carefully.
  2. Pretreat spots, stains before washing.
  3. Use the correct water temperature.
  4. Use the right kind and amount of washing product.
  5. Know your washer and how to use it.
  6. Use the right washing action.
  7. Rinse items thoroughly.
  8. Dry clothes completely.
- b. Sorting
  1. Purpose: to separate the items that could in some way damage other garments. Some things to consider when sorting clothes are color, type of fabric, garment construction, amount and kind of soil, and size of item.
  2. Suggested sorting guide
     - a. sturdy white and colorfast items
     - b. non-colorfast items
     - c. heavily soiled items
     - d. delicate items
  3. Before and during sorting
     - a. mend and repair holes, snags, rips, tears, pulled seams, and weak spots
     - b. empty pockets, remove buckles and other non-washable ornaments and trims
     - c. close zippers and other fasteners
     - d. pretreat garments
- c. Pretreating
  1. Definition: special treatment of heavy soil, spots and stains before washing. The sooner a spot or stain is treated, the easier it is to remove. Some stains may be set by washing. Some oily stains harden with age and become almost impossible to remove. Many stains are hard to see once the fabric becomes wet. Try to identify what caused the stains and treat them accordingly.
  2. Common stains which require pretreatment.
- d. Detergents and bleach
  1. Two types of detergent:
     - a. light duty—designed for washing lightly soiled fabrics such as silk, wool, lingerie, hosiery Ex. — Chiffon, Dreft, Ivory, Joy, Lux, Swan, Thrill, Vel, Dove, Palmolive, Woolite
     - b. heavy duty—workhorses for the family wash; more effective than light-duty detergents for cleaning moderately or heavily soiled fabrics Ex. — normal sudsing: Ajax, Bold, Breeze, Cheer, Drive, Fab, Gain, Oxydol Plus, Premium Duz, Punch, Silver Dust, Surf, Tide, Trend, Whisk, Cold Power, Era, Dynamo; low sudsing: All, Dash, Cold Water All, Salvo Tablets

2. Bleach
   - a. meant to assist detergent—not replace it; chlorine bleach is also an excellent disinfectant
   - b. three types—liquid chlorine, powdered chlorine, oxygen or all-fabric bleach; all should be used with caution
   - c. liquid chlorine—offers best stain removal but greatest possibility of clothing damage; never use on silk, spandex, wool or anything containing these fibers
     Ex. — Clorox, Purex, White Sail, Texize
   - d. powdered chlorine—more gentle than liquid and produces basically the same results
     Ex. — Action, Purex, Stardust
   - e. Oxygen bleach
     able fabrics, but only effective in hot (140-160 degrees Fahrenheit) water
     Ex. — Clorox II, Lestare, Snowey, All Fabric Beads-O'-Bleach

E. Water temperatures
   1. Hot—white or colorfast cottons, linens and rayons
   2. Warm—permanent press, knits, synthetics, blends, sheer, lace, acetate, plastic
   3. Cold—bright colors, colors that are not colorfast

F. Washing Action
   1. Normal—cottons, linens, rayons, permanent press, knits, synthetics, blends (sheer, lace, acetate, plastics, and clothes with delicate construction)
   2. Medium
   3. Slow—woolens, aged quilts, curtains, etc., and very delicate or fragile items

G. Reminders

II. Rules for ironing

A. General rules
   1. Iron fabric lengthwise to prevent stretching.
   2. Collars, cuffs, and facing are usually ironed first because they take the longest to dry.
   3. Hang or fold clothes immediately, fastening hooks, buttoning and closing zippers.
   4. Allow items to dry completely before pulling them away; damp clothes wrinkle.

B. Special care
   1. Pile fabrics such as velvets and corduroy will keep their texture better if ironed on wrong side over a terry towel.
   2. Dark fabrics, silks, acetates, rayons, linens and some wools must be pressed on the wrong side to prevent shine; a pressing cloth is useful.
   3. Check the label before starting to iron, to ascertain recommended temperature; if there is no instruction or the material is a blend, use lowest temperature.

Worksheet 1: Physical and Psychological Contribution of Maintenance Tasks

List possible tasks and their resulting physical and psychological assistance.

TASK	ASSISTANCE	
	PHYSICAL	PSYCHOLOGICAL

Worksheet 2: Commercial and Improvised Methods of Cleaning

ITEM	COMMERCIAL CLEANING AGENT OR PRODUCT	PROCEDURE TO CLEAN, DUST OR STRAIGHTEN	ALTERNATIVE PRODUCTS, TECHNIQUES TO USE - IF RESOURCES ARE LIMITED
Mirrors			
Wood furniture			
Walls			
Bathtubs			
Counter tops			
Baseboards			
Tile floors			
Hardwood floors			
Carpet			
Ovens			
Windows			
TV sets			
Ceilings			

UNIT B: FOOD AND NUTRITION

ESTIMATED TIME: 7 hours

SUGGESTED INSTRUCTOR: Nutritionist, registered dietition, home economist

INTRODUCTION

At some time every homemaker-home health aide will prepare food for an individual or for a family and therefore, needs to be knowledgeable about food and nutrition and how it contributes to the physical, social and psychological well-being of people. The plan for homemaker-home health aide services for the individual or family should indicate responsibility for food preparation. Effectiveness in helping the individual or family to maintain or improve their eating habits and nutritional status requires knowledge about food and its nutritional value, meal planning, shopping for food and an understanding of the cultural, religious, social, psychological and economic factors which influence people's use of food.

Homemaker-home health aides should know whom they can call on for guidance when problems arise in providing dietary care for individual or families. In addition to the supervisor and physician, necessary guidance may sometimes be obtained from the local hospital dietition, a nutritionist, or a nurse employed by a local health department or visiting nurse association.

An effort should be made to have a registered dietition or qualified nutritionist teach the Section dealing with Nutritional Problems of the Aged and Ill, as well as the Section on Modified Diets. Assistance in finding qualified instructors may be obtained through the local or state health departments, the local Visiting Nurse Association, or the state or local Dietetic Association.

EXPECTED OUTCOME

The trainee will be able to:

- Identify how foods and nutrition contribute to physical, social and psychological health

- Discuss how the care plan is followed in carrying out food-related responsibilities, including modified diets
- List factors influencing individual and family food habits
- Plan meals that provide for adequate nutrition for individuals and families on both general and modified diets
- Shop for, plan, prepare and serve food attractively and economically, with attention to eating habits and preferences
- Prepare and serve food for the elderly, ill and persons on modified diets, including how to feed those who cannot feed themselves

CONTENT

Part 1: Importance of Food and Nutrition

The contribution of food and nutrition to health is the subject of this discussion. Exercises 1 and 2 may be used.

Basic to maintenance of good health is adequate nutrition. A well-balanced diet is necessary for growth and the maintenance of normal body functioning. The individual who has good eating habits and is well-nourished will have the energy to carry on life's activities. Good nutrition and resulting good physical health contributes to a positive outlook on life.

It has been demonstrated that children who are well-nourished do better in school than those who are not. "Nutrition during an individual's 30's and 40's sets the stage for the degree of health maintained during the later years. There is a great pay-off for maintaining good health and nutrition during those years."[1]

Dr. Robert Butler, director of the National Institute on Aging, suggests that one cause of "senile dementia" could be enemia due to poor diet.[2] A recent study report on disabled elderly persons emphasizes "the social necessity of keeping the sick and infirm in the mainstream of American life and of interrupting the pattern of unchecked impariment of faculties -- eyesight, hearing, teeth --

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1. Fay Strayer. Homemaker-Home Health Aide Manual. Ames, IA: The University of Iowa Press, September 1975, pp.125-140.
2. "Washington Report on Long-Term Care." Vol.5, No.19, May 7, 1976. McGraw Hill.

and poor nutrition which triggers institutional placement."[3]

Good nutrition is important in the care of the ill and aged: in maintenance of good muscle; prevention of decubiti; promotion of wound healing and recovery from the stress of illness. The care plan will indicate the special nutritional needs of the ill individual and/or families that need improved patterns of eating and well-balanced diets.

Nutrients required for good nutrition include:[4]

- Carbohydrates are an important food for calories needed to keep the body functioning and for energy to carry on daily activities. Complex carbohydrates, such as found in potatoes, bread, cereal, rice, spaghetti and similar foods are especially desirable. Simple carbohydrates, such as found in sugar, syrups, jelly are less desirable

- Proteins play a major role in growth and in the replacement of tissue in the body; and can be broken down for energy when needed. Proteins are found mainly in meat, fish, fowl, eggs, soy beans, nuts, peanut butter, legumes, Dried beans. Milk and milk products are important sources of protein

- Fats are intended for storage of energy and also provide the body with insulation and padding, since they are stored mainly under the body skin. Fats are found in all types of oil, butter, margarine, cream, meat, etc. In general, it is thought advisable to substitute some vegetable oil, which is high in polyunsaturated fatty acids (such as corn and safflower oils), as well as margarine which is high in liquid oil for some or all of the animal fat or hydrogenated vegetable fats used in cooking

- Vitamins are essential for proper body functioning. They differ from the other nutrients in that they are not used for energy

- Minerals, although needed in very small amounts, are essential to normal body functioning

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3. Van Dyke, Frank and Virginia Brown. "Organized Home Care: An Alternative to Institutions." Inquiry 9:2 (June 1972). Chicago: Blue Cross Association, pp.3-16.

4. Adapted from: "Family Food-Daily Food Guide." The Cooperative Extension Service, Bulletin HS-9. The University of Minnesota, St. Paul: 1975.

- Water. About two-thirds of the total body weight is made up of water. Next to oxygen, it is most immediately important to life

- Fiber is necessary for good bowel function and is found in bran, whole grain cereals and breads, fresh fruits and vegetables and also in dried fruits

Part 2: Meal Planning

The instructor may wish to use visual aids - as may be obtained from a State Health Department, or through the National Dairy Council.

Most foods contain more than one nutrient and no single food furnishes all the necessary nutrients in the right proportion to maintain health. A Daily Food Guide is one way of selecting foods that will supply essential nutrients in recommended amounts. A well-balanced diet requires some food from each food group every day.

Milk is important for calcium needed for bones and teeth, as well as other minerals, vitamins and protein. Recommended daily: whole or skim milk, buttermilk, evaporated milk (as a beverage or in cooking) or yoghurt.

Children -	under 9	2-3 cups	daily
	9-12	3 or more cups	daily
	teenagers	4 or more cups	daily
	adults	2 or more cups	daily

For pregnancy and lactation: 4 or more cups daily

Milk equivalents in calcium:

1 oz. cheddar cheese = 2/3 cup milk
1/2 cup cottage cheese = 1/3 cup milk
1/2 cup of ice cream = 1/4 cup milk

Some ways of incorporating milk in the diet to cut food costs includes: puddings, cream soups, beverages such as eggnog, milk shakes and in cooking cereals. Use non-fat skim milk as a beverage and in cooking.

To prepare double concentration milk: add powdered skim milk to milk instead of water. This can be a means of providing valuable extra protein and nourishment when used in cooking, for beverages.

Some individuals complain of developing gas or diarrhea when they drink milk, particularly in large amounts. These people are said to have a lactose (milk sugar) intolerance. Usually they can tolerate cheese, such as American or Swiss, and sometimes buttermilk and yoghurt.

Foods other than milk which provide calcium are: greens, such as turnip, collard and mustard; kale; sardines; canned salmon and soybean curd.

Meat, Fish, Poultry or Substitute - two or more servings (5-6 ounces daily). Count as one serving 2-3 ounces lean cooked meat, fish or poultry.

Substitute for 1 oz. of meat or fish or poultry

1	egg
1/2	cup dried beans, peas or lentils (cooked)
2	Tbs. peanut butter
1	oz. cheddar cheese
1/4	cup cottage cheese

In addition to providing protein, these foods are good sources of many minerals and Vitamin B complex. Meat, particularly, is a rich source of iron.

Vegetable and Fruit Group - four or more servings daily, counting 1/2 cup or 1 medium piece of fruit as a serving. Fruits and vegetables are important sources of Vitamins A and C, minerals such as potassium, as well as fiber.

One serving of a good source of Vitamin C or two servings of a fair source should be used daily. They are:

Good Sources

Grapefruit or grapefruit juice; orange or orange juice; cantaloupe; strawberries; fresh guava; mango or papaya; broccoli; brussels sprouts; green pepper; sweet red pepper.

Fair Sources

Honeydew melon; lemon; tangerine or tangerine juice; watermelon; asparagus tips; raw cabbage; collards; cauliflower; watercress; kale; kohlrabi; mustard greens; potatoes and sweet potatoes cooked in the jacket; spinach; tomatoes, tomato juice, turnip greens.

Bread and Cereal Group - four or more servings of whole grain or enriched bread or cereal are needed. This group is an important source of the B Complex Vitamins and various minerals. Whole grain breads and cereals are high in fiber content.

One serving equals one slice of bread or 1/2 cup cooked cereal, rice, macaroni, etc., or 3/4 cup of most dry cereals or 1 small biscuit, muffin or tortilla.

The foods in the four above mentioned food groups make up the foundation of a good diet and provides reasonable assurance that nutrient needs are met. Additional amounts of foods from these groups, as well as other foods may be used to round out meals and provide adequate calories.

Other Important Considerations in Meal Planning

Fluid needs are met by drinking water, as well as beverages such as milk, fruit juices, tea, coffee, soups, gelatin, Italian ices, carbonated beverages. Inadequate fluid intake results in dehydration and constipation. A minimum of 4-6 cups daily is desirable.

Balancing calorie intake against calories expended so as to maintain a normal body weight. An excess of foods high in fat and sugar often predispose one to becoming overweight.

Moderation in use of salt in preparing food is desirable.

Exercise 2 may be helpful in discussing the adequacies of patterns of eating.

Meal Planning and Meal Patterns

Families differ in their eating patterns. Some may eat lightly at noon and have a heavy meal in the evening. Some may eat a light breakfast and have light snack at mid-morning. The homemaker-home health aide will need to find out the meal patterns of the family and plan for meals away from home, and the kind of food usually eaten. If nationality and ethnic groups are present in the community, it is necessary to learn about the types of food and how they are to be prepared. One example is that of the orthodox Jewish family that maintains a kosher kitchen. *Exercise 1 may be used for discussion of difference.*

This is a sample meal pattern. Changes will need to be made to meet the patterns of a particular family.

Breakfast:	fruit or fruit juice cereal and milk and/or egg or other protein food bread and butter or margarine beverage
Lunch or Supper:	meat or other high protein food vegetable (may be in salad, soup, or combined in casserole meal) bread or other grain product, butter or margarine simple dessert (fruit or pudding) beverage, including milk

Dinner: meat or other high protein food
potato or substitute, such as rice, noodles, etc
green or yellow vegetables (some may be in a salad)
bread and butter, or margarine, if desired
dessert - can use fruit or milk dessert
beverage, including milk

Some dishes combine several foods in casseroles and stews. Foods used in these dishes do not need to be repeated in the meal. For example, if a casserole uses a bread topping, bread and butter would not be needed. If a casserole includes enough vegetables, other vegetables might not be needed. When planning dishes that combine foods, make sure there is enough of each to enable a person to get the needed amounts for good nutrition. (For example, a single cup of vegetables in a stew may not fill the requirement for a family of two or more and an extra vegetable, perhaps in a salad, would be needed.)

Variety in the diet is necessary. No one food is perfect. The best way to insure getting enough of all the needed nutrients in a diet is to eat a variety of foods. Each meal should contain at least one serving from each food group.

Variety in color, shape, flavor and consistency contributes to making meals attractive and appealing.

Part 3: Food Shopping

Shopping for and safe storage of food will be the next topic. The instructor may wish to use Exercise 3 for practice in shopping and storing foods. The homemaker-home health aide may at times need to plan menus for the family and do the shopping. Therefore, it is necessary that the homemaker-home health aide know how to shop economically and care for the food after its purchase.

At the market or grocery store

- Compare different brands of the same food. A store brand or no-frills brand may be cheaper than a nationally advertised one

- Consider they way in which the food will be used. For example, use a cheaper brand of tomatoes for a casserole dish where appearance is not so important. Lower grade eggs are good to use in cooking

- Read the label to be sure you are getting the kind and amount of product you need

- Use unit pricing where this is available

- Consider cost per serving

$$\frac{\text{Cost of item}}{\text{Number of servings}} = \text{Cost per serving}$$

- Buy for cash. It is more economical

- Compare prices. Most stores have "specials" priced below regular levels. These suggest best buys. Don't be tempted, however, buy what appears to be a "good buy" on an item beyond your price range (for example, steak when you should be buying hamburger)

- It is usually cheaper to buy staples and plain ingredients rather than processed or ready-mixed foods. For example, buy a head of cabbage rather than a package of cole slaw, plain macaroni and plain cheese rather than a packaged mix, potatoes and mayonnaise rather than potato salad. However, there will be times when the savings in time or the lack of use for leftovers or of a place to store them makes it worth while to buy such labor-saving foods

- Buy in quantities as large as practical. Don't buy more than you can store adequately and use in a reasonable time

- Buy foods that are in plentiful supply, particularly fresh fruits and vegetables when they are cheaper and at their seasonal peak. Smaller pieces of fruit are often less expensive than large or jumbo sizes

- Buying meat requires consideration of quality, cut, and particularly the amount of waste. The amount of inedible bone, fat, and gristle is an important factor in buying beef, pork, lamb and veal. Short ribs may cost less per pound than hamburger, but yield only one-third or one-half as many servings per pound. Consider the more inexpensive cuts of meat: flank, neck, shin, chuck, heart, liver, and kidney. Skillfully cooked, these are delicious and offer excellent nutritional value. Chicken generally offers excellent value. Buying it whole rather than cut up is a further way of cutting food costs

- Compare the costs of fresh, frozen and canned foods to see which offers the best value

- Margarine may be a better buy than butter. In general, olive oil is more expensive than other vegetable oils. Leftover meat drippings can be used for a variety of cooking purposes

Part 4: Meal Preparation

This topic is subject to the background of the trainees and their experience in measuring ingredients and in preparing foods in a variety of ways: boiling, broiling, sauteeing, roasting, braising, *baking, poaching, stewing, frying. Special instructions may be given to augment the trainees' basic knowledge and experience, such as emphasizing the need for accurate measuring in the preparation of modified diets and special formulas as well as in baking and other procedures.*

General Guides For Meal Preparation

Homemaker-home health aides should be encouraged to find out how persons like food prepared; seasonings they enjoy, etc. It is helpful to have recipes and menus available with suggestions as to how to combine and season food. A last minute rush can be avoided by partially or fully preparing some dishes ahead. Care must be taken in protecting and storing food prepared in advance.

Using leftovers can save time and money. Leftovers may even need to be planned for so that the person can get a meal on days that he/she is without help. Many nutritious casserole dishes and desserts make good use of leftovers. Some leftovers can add food value or a fresh touch to a dish: bits of leftover fruit added to muffins, leftover vegetables in an omelet and scraps of meat used in a macaroni dish are examples. Leftover water from cooking vegetables may be used for gravies, soups, etc.

Fuel can be conserved in a number of ways:

- When food has started to boil, it will continue to cook even if the heat is turned very low

- Cook foods only until tender. Overcooking wastes fuel and may destroy the attractiveness and food value

- One dish meals can save time and fuel

- When using the oven, plan double or triple use of it. Starting with a meat loaf, for example, you can bake potatoes and a cake with little or no extra fuel cost

A one burner portable oven is often satisfactory for baking.

In preparing small quantities, cook in both the top and bottom of a double boiler, pudding in the top half, and carrots in the bottom.

Serving some raw fruits and vegetables each day for good nutrition, fuel can also be saved.

A hot plate can be used in ingenuous ways to prepare balanced, varied and nourishing meals. Preparing a one dish meal is a good way to overcome the problem of limited facilities. Into a single pot can go both the vegetables and the meat or other protein food for a nourishing main dish.

Part 5: Proper Food Storage, Food Sanitation and Kitchen Safety

General storage points:

- Do not purchase more than you have room for
- Keep refrigerator and freezer units in proper working condition. Clean and defrost periodically
- Refrigerator temperatures should be maintained between the range of 36 and 40 degrees Fahrenheit
- Freezer temperature should be maintained at zero degrees Fahrenheit
- Check for date when buying perishables. Use packaged foods before expiration date
- Discard foods which show spoilage
- Keep foods in refrigerator properly covered or wrapped
- Dry ingredients such as flour, sugar, and pasta products should be kept in covered containers
- Foods in refrigerator as well as dry storage should have room around them for air circulation
- Check dry storage areas periodically for insect and rodent signs

Guidelines for specific foods

- Fresh meat, poultry and fish should be removed from the store wrapper and rewrapped
- Cured and smoked meats, such as ham, frankfurters, bacon and sausage should be wrapped while they are stored in the refrigerator. They keep longer than fresh meats, although bacon and sausage are likely to change flavor if not used in a reasonable period
- Eggs, dairy products, open jars of salad dressing and most fats require refrigeration. Fats should be kept covered so that they do not absorb odors from other foods. Cheese should be well wrapped
- Fresh fruits and vegetables should be left out until ripe before putting them into the refrigerator
- Frozen foods should not be kept too long. Do not refreeze after thawing

Good food handling practices

- Keep work surfaces clean and the work area well organized and orderly so that each part of the work may be carried through to completion without hazard
- Use only clean utensils in preparing, cooking and serving food
- Use clean dishrags and towels. Air dry, if possible
- Use very hot water and detergent to wash utensils and dishes
- Refrigerate unused foods and clean up any spoilage promptly
- Cover all foods that are refrigerated. Some foods have strong odors and will ruin the flavor of other, more bland foods
- Refrigerate warm foods before they cool. Prompt refrigeration discourages growth of bacteria that occurs when foods cool at room temperature
- Cook meats to the temperature indicated
- Wash fresh fruits and vegetables before using
- Use leftovers promptly
- Avoid eating eggs in a raw state, especially if they are cracked
- Use a clean spoon to taste food
- Do not use damaged cans which have bulging ends or are rusty
- Open sores or cuts on fingers or hand must be covered with clean bandages

Kitchen safety and cooking hazards

- Keep pot and pan handles position toward back of stove
- Avoid clothing with long flowing sleeves that may easily catch on pot handles and/or cause burns
- Clean up spills on floors immediately to prevent falling
- Avoid broken or chipped cooking utensils or serving pieces
- Turn off the range and oven when not in use

- Check electric cords on appliances periodically for worn places
- Avoid overloading electric outlets. Unplug those appliances that are not in use
- Dry hands before using electrical applicances
- Light the match before turning on gas to avoid gas build-up
- Extinguish matches before discarding them
- Store knives carefully
- Avoid putting knives or sharp instruments in a dish pan
- Use pot holders appropriately
- Keep drawers and cupboards closed

Part 6: Nutritional Problems of the Aged and Ill

The older person may not eat properly because of loss of appetite, difficulty in eating and because of financial problems. Maintaining energy and health depends on maintaining adequate nutrition.

Nutritional needs with advancing years do not change much, except for a somewhat lower calorie requirement. Care must be taken to provide for an intake of essential nutrients without excessive calories.

Methods and concerns in coping with common deterrants to an adequate food intake associated with the aged and/or ill person includes recognition of such facts as:

- Loneliness - importance of companionship at mealtime
- Decrease in sense of taste and smell - importance of serving meals which look, taste and smell good
- Small appetites - may need five or six small feedings of high quality foods. High protein -- high calorie beverages may be easier to consume than large amounts of food
- Chewing problems related to lack of teeth or poorly fitting dentures

  Use: tender cooked meats (moist cooking methods, using low cooking temperature), ground meats (beef, lamb, fresh pork, ham, veal), fish, eggs, cheese, legumes
- Fatigue - rest before meals may be beneficial

- Pain - serve food when pain relieving medication is most effective
- Constipation may lower appetite - corrected by increased fluids and fiber in diet
- Improper mouth care - a bad taste in the mouth detracts from enjoyment of food
- Depression - the person has lost interest in life and gives up eating
- Nausea - cold food is less apt to provide odor which often triggers nausea. Small, frequent feeding and eating slowly may be helpful

After a stroke, facial weakness and swallowing problems may make it difficult for a person to consume fruit juices and water. Thickened liquids, such as milk shakes, cereal gruels, purees, yoghurt, sherbet, gelatin and liquids frozen to a slush may be easier for the person to control.

Sometimes it will be necessary to feed persons who for some reason cannot feed themselves. The following are some points that will make being fed more pleasant:

- If possible, have the person sit up erectly as possible, or positioned for comfort
- The individual should be allowed to feed himself if he is able - give assistance when needed or asked for. Feeding oneself will give a person a feeling of independence
- Take time to make eating a highlight of the day
- Do not rush the feeding - a person can swallow only so fast
- Be understanding -- the person would feed himself or herself if it were possible
- Be gentle with forks and spoons
- Wipe off the corners of the mouth gently periodically throughout the meal
- Straws or training cup may aid in the feeding of liquids
- Do not mix all the food together; offer each food separately as it would be most commonly eaten
- Keep the conversation pleasant
- Individuals may prefer to hold the cup when drinking

- When offering a glass or cup, touch it to the lips

- Offer the person an opportunity to rinse his mouth after eating

- The person will feel less rushed if the one doing the feeding sits

- If the person is blind, explain where food is on the plate using the hands on a clock as an indicator. For example, mashed potatoes at the 5 o'clock position

- In case of one-sided facial weakness or paralysis, feed to the good side

Part 7: Modified Diets

The homemaker-home health aide should be aware of the importance of following directions for modification of diets as part of the treatment of the ill person.

Modified diets are an important and sometimes critical part of the treatment of persons with heart, kidney or liver diseases, diabetes and other health problems. Some medications may require restrictions of certain foods because of interactions between food and drugs. Other drugs may increase a person's requirement for specific nutrients. Whatever the modification, it is essential to assure that the individual received the essential basic foods necessary to maintain or improve his health status and hasten recovery and rehabilitation.

A modified diet is always prescribed by the person's physician. When a modified diet needs to be followed- the homemaker-home health aide should always be given a copy of the diet to guide her in shopping and preparing meals. Some agencies have nutrition consultants to assist in developing a diet regimen that is therapeutically acceptable and still considers the likes and dislikes of the individual.

It is important to help the person adhere to the prescribed diet. Problems encountered in compliance with the diet should be discussed with appropriate family members or person responsible for the person's medical care, as well as the patient's physician, visiting nurse, or supervisor.

Dietary Management of Diabetes

- Two kinds of diabetes are:

  - Adult onset or non-insulin dependent - weight control or weight loss is often the major factor in the management of non-insulin dependent diabetics. With weight loss these persons may again have normal blood sugar levels

- Insulin Dependent - (sometimes called Juvenile) - The aim of treatment is to establish good control which involves taking proper insulin dosage daily; following a prescribed diet and eating at regular intervals; having regular patterns of exercise or activity

The following are important conditions that may occur in diabetics and may require action by the homemaker-home health aide.

Hypoglycemia - associated with insulin-dependent diabetics:

- Cause - skipping meals; eating too little, increased physical activity, too much insulin
- Symptoms - hunger, nervousness, irritability, inability to concentrate, difficulty in talking, trembling. Onset is often sudden
- Treatment - the person needs sugar which can be quickly absorbed - candy, one-half to two cups of orange juice or gingerale

Hyperglycemia:

- Cause - too little insulin; failure to follow dietary restrictions; also infection, illness or stress
- Symptoms - increased urination, increased thirst, weight loss, dry skin. Patient will be spilling sugar in urine and possibly acetone. Eventually, if untreated, coma results
- Treatment- medical reevaluation of diet and medication

The homemaker-home health aide must understand that for the diabetic, eating meals at regular times is imperative. Mid-afternoon and bed-time snacks for some persons are needed to prevent rise and fall in blood sugar levels. It also provides a more constant supply of food to balance the effect of the insulin.

Two types of diet are used by persons with diabetes:

- Non-concentrated sweets - this is a well balanced diet which eliminates: sugar, syrups, honey, sweetened sauces, jellies, jams, marmalade, cranberry sauce, candy. This includes:
  - Prepared desserts, such as ice cream, cake, pies, puddings, jello
  - Fruits, canned or frozen with sugar
  - Sweetened fruit juices, fruitades, nectars

- Carbonated beverages containing sugar
- Molded salads to which sugar is added
- Glazed and candied fruits and vegetables
- Condensed milk
- Sweet rolls and cookies
- Sugar-coated cereals

- Diets based on the use of Exchange Lists for meal planning. (Set up by the American Diabetes Association and the American Dietetic Association.)

The instructor should use the Exchange Lists.

These diets are more restricted and require careful attention to measurement in the use of six food groups. The six food groups need to be explained in such a way that the homemaker-home health aides are sufficiently familiar with them to demonstrate ability to plan meals for one or more days, using the Exchange Lists and a meal plan.

The homemaker-home health aides also need to be able to identify foods and liquids which are suitable to use in meal planning for persons who are not up to eating their usual diet for one reason or another.

It is important that the individual on insulin eat and/or drink foods which will balance the insulin they have taken. Carbohydrates, found in foods from the milk, fruit and bread lists are the most important foods to be eaten if the usual diet is not tolerated.

Use of the dietetic foods, sold as suitable for persons on sugar restricted diets must be fitted into the individual's diet, if used at all. They may not be used in addition to the individual's regular food allowances.

Sodium-Restricted Diets

Sodium is restricted in the diets of people who have certain heart conditions and swelling because fluids are retained in the tissues, most noticeably in the feet and legs, or who have high blood pressure. The physician prescribes the level of sodium restriction he feels is necessary.

Sodium is found in many foods and is one of the two substances in salt. The large amount of sodium found in salt is the reason that salt is always restricted in these diets.

Persons requiring only mild restriction of sodium are sometimes advised:

- To use only a small amount of salt in cooking
- To avoid foods high in sodium, such as:
  - . Salty or smoked meat - bacon, bologna, chipped or corned beef, frankfurters, ham, meats koshered by salting, luncheon meats, salt pork, sausage, smoked tongue, canned meats
  - . Salty or smoked fish - anchovies, caviar, salted cod, herring, sardines, etc.
  - . Processed cheese or cheese spreads unless low-sodium dietetic cheese, such as Roquefort, Camembert, or Gorgonzola
  - . Regular peanut butter
  - . Canned, frozen and dried soups - bouillon cubes, powders and liquids
  - . Sauerkraut or other vegetables prepared in brine - pickles, relishes and olives
  - . Breads, rolls and crackers with salt topping - salted popcorn, potato chips, corn chips, pretzels, etc.
  - . Bacon fat, salted nuts, party spreads and dips
  - . Worcestershire sauce, meat and vegetable extracts

Barbecue sauces	Meat sauces
Catsup	Meat tenderizers
Chili sauce	Soy sauce

  - . Garlic salt, onion salt, celery salt - unless used lightly in place of regular salt
- Individuals requiring moderately low or strict low sodium diets may be advised to:
  - . Eliminate all salt in cooking: all foods canned or preserved with salt
  - . Limit or exclude regular bread (on moderately low sodium diets, individuals often are told to limit regular bread to 3-4 slices a day)
  - . Limit the amount of milk, eggs, meat on diet
  - . Exclude quick cooking cereals which are salted
  - . Exclude prepared cereals containing salt (all except puffed rice, puff wheat and shredded wheat)

    - Exclude regular butter and margarine
    - Use only medication prescribed by doctor. Many over-the-counter medications are very high in sodium
    - Read labels carefully to make certain that no salt or other form of sodium, such as monosodium glutamate, sodium nitrate, etc., has been added

- Use lemon, herbs and seasonings which can make low sodium meals flavorful and more palatable

Homemaker-home health aides may be encouraged to discuss seasonings they know can be used to make foods flavorful, for example:

With lamb - serve mint jelly, garlic

With pork - applesauce, onion, sage

With chicken - tarragon, sage, onion, paprika, lemon, butter sauce, cranberry sauce

With beef - peppercorns, dry mustard, paprika, oregano, etc.

With carrots - lemon, butter, orange rind, butter/sugar glaze, dill

- Use of salt substitutes - only with approval of physician. (Salt substitutes, being high in potassium, may be contraindicated for some individuals)

The homemaker-home health aide should be familiar with some rich sources of potassium for persons on blood pressure or diuretic medication and who require a high potassium food intake.

- Orange juice, prune juice
- Bananas, dried fruits (prunes, apricots, figs, raisens, dates)
- Nectarines, cantaloupe, orange, rhubarb, grapefruit
- Potato cooked in the skin, dried peas, dried beans; green leafy vegetables; tomato, winter squash
- Unsalted nuts, avocado

Low cholesteral - modified fat diets are prescribed to control the elevated levels of fat and cholesterol in the blood.

These persons are advised to:

- Use only skim milk and low fat cheese

- Use more fish, chicken turkey, veal -- limit lean lamb, beef, pork to about three meals a week

- Limit egg yolks to two or three a week

- Avoid organ meats -- liver, kidney, brains, etc. -- shellfish; fatty meats and desserts made with whole milk, cream or eggs in excess of allowance

- Avoid cream, butter, lard, meatdrippings, cocoanut oil and olive oil

- Use vegetable oils which are high in polyunsaturated fatty acids, such as corn oil, safflower oil; margarine which has liquid oil listed as the first ingredient on the label instead of partially hydrogenated oil

This diet differs from a low fat diet prescribed for persons having gallbladder disease or other digestive problems related to fat intake. For them all fat may have to be restricted, including vegetable oils and margarines containing liquid oil.

Dietary Management of Duodenal Ulcers - When a blank low-fiber diet is prescribed by the physician for a person having ulcers, the homemaker-home health aide must plan and prepare meals accordingly. Of special importance, however, for these persons is that they:

- Eat small frequent meals (every 2-3 hours)

- Eat slowly and chew well

- Avoid highly seasoned food, alcohol, coffee and various carbonated beverages

Exercise 4 may be used to ascertain the understanding of modified and special diets.

Many persons will receive suggestions for diets by friends and relatives. There are, also, the numerous fads and fallacies which may be used by persons receiving service. It is important that the homemaker-home health aide be aware of any departures from perscribed diets that may greatly change the dietary treatment. These should be reported to the supervisor or nutrition consultant.

Specific Reference For Instructors Use

Exchange Lists for Meal Planning, *American Diabetic Association and American Dietetic Association*, 1976.

Food for Fitness. A Daily Food Guide. *U.S. Department of Agriculture.*

Mitchell, Rynberger, Anderson and Dibble. *Nutrition in Health and Disease*, 16th *Edition*, 1976.

Planning Fat-Controlled Meals for 1,200 and 18,000 Calories; Planning Fat-Controlled Meals for Approximately 2,000-2,600 Calories. American Heart Association.

Robinson. Normal and Therapeutic Nutrition, 15th Edition, 1977.

Sodium Restricted Diet (500 mg. and Mild Restriction). American Heart Association.

National Dairy Council can provide excellent and attractive teaching materials.

SELECTED REFERENCES

American Home Economics Association. Handbook of Food Preparation. Washington, DC: American Home Economics Association, 1975.

Bratton, Esther C. Home Management Is... Boston: Ginn and Company, 1971.

Family Fare: A guide to Good Nutrition. U.S.D.A. Home and Garden Bulletin No.1. Washington, DC: July 1974, pp.24-25.

"Family Food - Daily Food Guide." The Cooperative Extension Service, Bulletin HS-9. The University of Minnesota, St. Paul: 1975.

Fetterman, Elsie. Money Management. Boston: Houghton Mifflin Company, 1976.

Kinder, Faye. Meal Management. The MacMillan Company, New York: 1978.

Lewis, Burns and Segner. Housing and Home Management. The MacMillan Company, New York: 1969.

May, Elizabeth, Eckhardt, Neva R. Waggoner, and Eleanor M. Boettke. Independent Living for the Handicapped and the Elderly. Houghton Mifflin Company, Boston: 1974.

Peck, Morgane, Sickler and Washington. Focus on Food. McGraw Hill Book Company, New York: 1970.

Shank, Fitch, Chapman and Sickler. Guide to Modern Meals. McGraw Hill Book Company, New York: 1970.

Simplified Diet Manual Study Guide. 2nd Edition. (Prepared by Dietary Consultants of the Iowa State Department of Health.) Published by Iowa University Press, Ames, IA: 1978.

Strayer, Faye. Homemaker-Home Health Aide Manual. Ames, Iowa: The University of Iowa Press, 1975.

"Training Manual for HomeCall Employees." HomeCall, Inc., Frederick, MD: 1977.

Van Dyke, Frank and Virginia Brown. "Organized Home Care: An Alternative to Institutions." Inquiry 9:2, pp.2-16. (Blue Cross Association, Chicago.)

Washington Report on Long-Term Care. New York, NY: McGraw Hill May 7, 1976. (Vol.5, No.19.)

"Your Budget." Money Management Institute, Household Finance Corporation, Prudential Plaza, Chicago, IL 60601.

Assessment - Unit C Nutrition

Please check True (T) or False (F) in answer to the following questions.

1. Good nutrition is important in the care of the ill and aged, because it:

   T___ F___ maintains good muscle tone

   T___ F___ prevents decubiti

   T___ F___ promotes healing

   T___ F___ helps in recovery from the stress of illness

2. Carbohydrates are important sources of energy, but are not needed for body function: T___ F___

3. Proteins play a major role in growth, but can also be broken down into energy: T___ F___

4. Fats store energy and provide insulation and padding T___ F___

5. Fiber is found in refined foods like white flour: T___ F___

6. Water is about 2/3 of the body weight and next to oxygen most important to life: T___ F___

7. Some people compain of gas and diarrhea when they drink milk in large amounts, but can usually tolerate cheese. sometimes buttermilk and yoghurt: T___ F___

Please complete the following:

8. Milk is a good source of

   ________________needed for bones and teeth

   ________________needed for growth

   _______________needed for normal body function

9. Too little fluid results in

   ____

   ____

   ____

10. In preparing some diets and formulas, it is important to

_____________________ accurately

11. List 6 common reasons why the ill and elderly may not take adequate amounts of food

_____________________ _____________________

_____________________ _____________________

_____________________ _____________________

12. A modified diet is always perscribed by the doctor

T___ F___

13. A modified diet should not consider the likes and dislikes of the person

T___ F___

14. The person with diabetes must eat meals at regular times

T___ F___

15. Hypogylcemia may be caused by too much insulin and skipping meals

T___ F___

16. Sodium is found in many foods

T___ F___

Answers to Above Questions

1. T, T, T, T
2. F
3. T
4. T
5. F
6. T
7. T
8. calcium, protein
   vitamins, minerals
9. dehydration, constipation
10. measure

11. loneliness
    small appetite
    chewing-teeth problems
    fatigue
    pain
    depression
    poor mouth care
    loss of taste and smell

12. T
13. F
14. T
15. T
16. T

AIDS

Exercise 1: Understanding Differences

Exercise 2: Meal Planning

Exercise 3: Shopping and Storage of Foods

Exercise 4: Adapting a Menu to Special Dietary Needs

Exhibit 1: Nutrients Required for Good Nutrition

Handout 1: Check Sheet on Sanitation Procedures

Handout 2: Safe Storage of Food

Handout 3: Shopping Tips

Handout 4: Check Sheet on Cooking Hazards

Exercise 1: Understanding Differences

This exercise focuses on the importance of considering individual, family, and cultural differences in preference for certain foods.

- Read or handout the summary case study
- Case study:*

> Wanda White is a young, black woman, age 22, who was raised in New York City. Her grandmother, Mrs. Gibson, age 73, lives in Atlanta, in her own home, and her health is failing. She asked Wanda to come live with her and take care of her.
>
> The first week Wanda was there, the meals-on-wheels continued to bring the main meal for her grandmother daily. At the end of the week, Wanda was settled and the meals-on-wheels was discontinued. Wanda is very proud of her black culture and eats "soul food" regularly in New York. She assumes her grandmother is also fond of chitlens, etc., and likes to eat them frequently. However, Mrs. Gibson has never eaten "soul food" regularly and after a month of politely suggesting that Wanda fix her some other food, to no avail, begins to stop eating her meals.

- Guided Discussion, including:

> What happened? How can the situation be resolved? How could the situation have been avoided? Do people of the same racial/cultural heritage always like the same things or share all of the same customs and habits?

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* Occupational Home Economics Education Series - Care and Independent Living Service for the Aging. Section VI. Nutrition. Superintendent of Documents, U.S. Government, Washington, DC.

Exercise 2: Meal Planning

This will provide an opportunity to practice meal planning by actually planning meals for several case situations.

- Each trainee should prepare a one day menu for each situation or the group can plan and their choices placed on a chart or board.
- The situations are:
  - An elderly person living alone who eats all meals at home. This person refuses to drink milk. Meals need to be especially economical.
  - A family of two adults and three children (ages 7, 4, and 2). Person who prepares food is temporarily disabled. One adult eats noon meal away from home. Seven year old in school. Family does not eat red meats.
  - Two elderly persons who have a noon meal delivered. One does not like green leafy vegetables.
- Discuss in terms of nutritional adequacy, diet variety, and appearance, economy, and acceptability.

Exercise 3: Shopping and Storage of Foods

This exercise is designed to allow for practice in determining the most economical form of a food to purchase and the best way to store that product.

- Give out sample menu to each trainee.
- On the left side ask them to write the most economical form of that item to purchase.
- On the right side ask them to state how they would store the menu items.
- Discuss variations in the trainees perceptions.

Exercise 4: Adapting Menu to Special Dietary Needs

A one-day meal plan may be given to each trainee to use as a basis for applying information regarding nutrition and special diets. Using the attached format, assess whether or not the menu meets the criteria for a well-balanced diet and subsequently adapt it for diets that meet requirements of:

- Low income
- Increased fiber
- More calories
- Dental problems
- Mild sodium
- No salt in cooking (person finds food tasteless without salt)
- Non-concentrated sweet diabetic
- 1,500-calorie exchange diet for a diabetic
- Low cholesterol diet

EXERCISE 4: ADAPTING A BASIC MENU TO SPECIAL DIETARY NEEDS WORKSHEET

BASIC MENU	To reduce food cost	Increase fiber	Increase calories	Dental problems	Mild low sodium	No concentrated sweets	Low cholesterol	1500 calorie diabetic
Breakfast 4-oz. Orange Juice 1 Soft-cooked Egg ½ cup Farina 1 slice Wheat Toast 2 teaspoons Butter 1 cup Milk and/or Coffee	Use canned or frozen juice; day-old bread; margarine; powdered milk.	Whole orange; Wheatena; whole wheat toast.	Cook cereal in milk. Extra butter.					
Lunch								
Dinner								

Use same procedure for:
- cooking with herbs and seasonings
- full liquid diet
- other

Handout 1: Check Sheet on Sanitation Procedures

In the kitchen, do you:

NO	YES	
( )	( )	Keep work services clean and the work area well organized and orderly so that each part of the work may be carried through to completion without hazard?
( )	( )	Use only clean utensils in preparing, cooking, and serving food?
( )	( )	Use clean dishrags and towels?
( )	( )	Use very hot water and detergent to wash utensils and dishes?

In handling foods, do you:

( )	( )	Refrigerate unused foods and clean up any spillage promptly?
( )	( )	Cover all foods that are refrigerated? Some foods have strong odors and will ruin the flavor of other, more bland foods.
( )	( )	Refrigerate warm foods before they cool? Prompt refrigeration discourages growth of bacteria that occurs when foods cool at room temperature.
( )	( )	Cook meats until they are done? Temperature charts are given in most basic cookbooks.
( )	( )	Wash fresh fruits and vegetables before using?
( )	( )	Check expiration dates now on most foods before purchasing? Usually latest date will be found on package at back of display.

Handout 2: Safe Storage of Food

A. 1. Do not purchase more than you have room for

2. Keep refrigerators and freezer units in proper working condition

3. Refrigerator temperatures should be maintained between the range of 36 and 40 degrees Fahrenheit

4. Freezer temperatures should be maintained at zero degrees Fahrenheit

5. Use foods by expiration date on package. Check if date is that at which it is to be sold

6. Discard foods which show spoilage

7. Keep foods in refrigerator properly covered or wrapped

8. Dry ingredients such as flour, sugar, and pasta products should be kept in covered containers

9. Foods purchased less recently should be used first. A rotation system should be used for canned goods.

10. Foods in refrigerator, as well as dry storage, should have room around them for air circulation

11. Check dry storage areas periodically for insect and rodent signs

B. 1. Meat, poultry, fish. It is necessary to keep these foods cold, so store them in the refrigerator at 30 to 40 degrees F.

Poultry, fish and fresh meat such as roasts, chops, and steaks should be allowed some air. Loosen any tight coverings. Cover the food again loosely, and use within a few days.

Ground fresh meat and variety meats, especially liver and brains, spoil more quickly than others. Store loosely wrapped; cook within one or two days for best flavor or wrap in freezer paper and freeze.

Cured and smoked meats, such as ham, frankfurters, bacon, and sausage, smoked and unsmoked, may be kept tightly wrapped while it is stored in the refrigerator. They keep longer than fresh meats, although bacon and sausage are likely to change flavor.

Keep cooked meat, poultry, fish, broth, and gravies covered and in the refrigerator. Use within a few days or wrap in freezer paper or freezer bag and freeze.

2. Eggs. Eggs retain quality well if they are refrigerated. An egg carton or covered container helps prevent loss of moisture through the porous shell. Eggs should be stored small end down to keep the yoke centered.

3. Fresh fruits and vegetables. For best eating, most fruits and vegetables should be used fresh from the garden or orchard. But if they must be held a few days, follow the storage guide below:

   It is often best to let certain underripe products ripen before putting them into the refrigerator. If fresh and sound, avocados, peaches, pears, plums, and tomatoes will ripen in the open air at room temperature.

Storage Guide

Keep refrigerated and covered:

Asparagus
Beets
Beans, snap or wax
Broccoli
Cabbage
Carrots
Cauliflower
Celery
Corn, husked
Cucumbers
Greens
Onions, green
Parsnips
Peas, shelled
Peppers, green
Radishes
Turnips

Keep refrigerated uncovered:

Apples (Mellow)
Apricots
Avocados
Berries
Cherries
Corn, in husks
Grapes
Nectarines
Peaches
Pears
Peas, in pod
Plums
Tomatoes

Keep at room temperature or slightly cooler (60 to 70 degrees F).

Apples (Hard)
Bananas
Grapefruit
Lemons
Limes
Melons
Onions, dry
Oranges
Pineapples
Potatoes
Rutabagas
Squash
Sweet Potatoes

Corn stays fresher longer if not husked, but whether husked or unhusked, it loses its sweet flavor and becomes starchy very rapidly. Carrots and beets wilt less with the tops removed. Potatoes should be stored in a dark place to prevent budding. To keep berries in best condition, pick them over and store them unwashed in the refrigerator. Watch berries for mold.

4. Fats and Oils. Refrigerate lard, butter, margarine, drippings, and rendered fats, and opened containers of salad oil. Hydrogenated fats (certain shortenings sold under brand names, such as Spry, Crisco, Swiftning) can be kept at room temperature. Keep all covered.

   Open jars of salad dressing should be kept in the refrigerator for finest flavor. To retain salad dressing's smooth texture, keep it from freezing.

5. Canned foods. Store in dry place at room temperature, preferably not above 70 degrees F.

6. Frozen foods. Keep in freezing unit of refrigerator for not more than one week; for longer storage, keep in a freezer at 0 degrees F. Refreezing after thawing lowers quality.

7. Dried foods. Store dried foods in tightly closed containers at room temperature, preferably not above 70 degrees F. In warm, humid weather, move them to the refrigerator.

   Store dried eggs in unopened packages in a cool place (not over 55 degrees F.), preferably in the refrigerator. After opening, keep in tightly covered can or jar in refrigerator.

   Instant dry whole milk does not keep as well as instant nonfat dry milk because of its butterfat content. After the container has been opened, instant dry whole milk should be stored, tightly covered, in the refrigerator.

   Store instant nonfat dry milk in a closed container at room temperature (preferably not above 75 degrees F.). After reconstituting dry milk, refrigerate it as you would fresh fluid milk.

Handout 3: Shopping Tips

At the Market or Grocery Store

1. Compare different brands of the same food. A store brand may be cheaper than a nationally advertised one.

2. Consider the way in which the food will be used. For example, use a cheaper brand of tomatoes for a casserole dish where appearance is not so important.

3. Read the label to be sure you are getting the kind and amount of product you need.

4. Consider cost per serving:

$$\frac{\text{Cost of item}}{\text{Number of servings}} = \text{Cost per serving}$$

5. Buy for cash. It is more economical, and saves in the long run.

6. Compare prices. Most stores have "specials" priced below regular levels. These suggest best buys. Don't be tempted, however, by what appears to be a "good buy" on an item beyond your price range (for example, steak when you should be buying hamburger).

7. It is usually cheaper to buy staples and plain ingredients rather than processed or ready-mixed foods. For example, buy a head of cabbage rather than a package of cole slaw, plain macaroni and plain cheese rather than a packaged mix, potatoes and mayonnaise rather than potato salad. However, there will be times when the savings in time or the lack of use for leftovers or of a place to store them makes it worth while to buy such labor-saving foods.

8. Buy in quantities as large as is practical. Don't buy more than you can store adequately and use in a reasonable time.

9. Buy foods that are in plentiful supply. Seasons don't mean as much as they did a few years ago, but many items still have relatively large seasonal increases in supplies and therefore reductions in price. Foods, particularly fresh fruits and vegetables, are cheaper and better at their seasonable peaks.

10. Buying meat requires consideration of quality, cut, and particularly the amount of waste. The amount of inedible bone, fat, and gristle is a important factor in buying beef, pork, lamb and veal. Short ribs may cost less per pound than hamburger, but yield only one-third or one-half as many servings per pound. Think in terms of cost per serving rather than cost per pound. Lower grades of meat have less

fat and offer more for your money. Consider more inexpensive cuts of meat: flank, neck, shin, chuck, heart, liver, and kidney. Skillfully cooked, these are delicious and offer excellent nutritional value. Remember that you can "stretch" meat flavor by using small quantities in casserole dishes with such "extenders" as vegetables, potatoes, macaroni, and rice.

11. Chicken as a good buy. Chicken is now one of the better buys. A few years ago it was a luxury. With a very few exceptions, today's fryer is an all-purpose bird that can be prepared by most cooking methods. It is also the best bargain in buying chicken. A few pennies can be saved by purchasing a chicken whole rather than cut-up. Parts not used in the main dish, such as the neck, back, gizzard and liver, make excellent broth or gravy, and the meat from these parts can be used in casserole dishes.

12. Fresh fish and budget-stretcher. Inquire about the varieties of fish available in plentiful supply at the time of shopping. Whole fish are cheaper than steaks and fillets. Remember, as when buying meat, think in terms of price per serving rather than price per pound. You will find there is little or no waste in a fish steak or fillet. On the other hand, if you are preparing a fish chowder, use can be made of the head and other parts. This may be your best buy. And, perhaps most important of all, be sure what you buy is fresh and has been properly stored and refrigerated.

13. Choose wisely among canned and frozen foods. In canned foods, you often use second or "utility" quality when you are buying for use in stews and casseroles. Reverse your purchases of top quality vegetables "as is" or in plain cooked dishes. Avoid nationally advertised brands and buy the cheaper, but usually as good, brands under supermarket labeling. Compare carefully the cost per serving when choosing among fresh, canned, and frozen forms of the same food. For example, a pound of fresh peas in the pod will make only about two half-cup servings, but a regular-size package of frozen peas will serve three or four. When buying frozen food, be sure what you are buying is frozen solid and has no evidence of having been thawed; refreezing lessens the quality of frozen foods.

14. Lower grades of eggs. The B and C grades are good for uses where appearance and delicate flavor are not of main importance, such as baked dishes, custards, cakes, sauces, and salad dressings. Top quality eggs are used when they are to be served poached, fried, or soft cooked. In the late summer and fall it is usually cheaper to buy medium or small eggs rather than the large ones, but you will want to inquire into the price per ounce before making this decision. For the most economical buying, large eggs must weigh 24 ounces per dozen; medium 21 ounces; and small, 18 ounces.

15. Milk can be bought in many forms -- choose the best one for the family. Milk is cheaper when bought at carry-home stores or supermarkets than when delivered to the home. Skimmed one or two percent milk is usually cheaper than whole fresh milk and is equivalent in nutritive value (except for fat content). Evaporated milk is usually cheaper than whole milk and can be substituted for any use to which milk is put, but it is particularly useful in cooking. Instand nonfat dry milk is even cheaper and can be used for many purposes. This form is easily reconstituted and is palatable when well chilled. It can be added to many dishes to improve their food value. It lacks the butterfat content of whole milk, but can be safely used by the whole family except children under two years of age if the rest of the diet includes sufficient butter or fortified margarine. Instant nonfat dry milk is an excellent food for a weight reducing diet.

16. Fresh fruit and vegetables in season are usually cheaper than the same items canned. However, this is not always true, so compare fresh and canned as a purchase by our standard rule, price by serving. Apparent freshness and eye appeal are as good a criterion as any in selecting vegetables. Consider also the possiblity of buying slightly damaged or bruised produce that has been reduced in price for a quick sale; if you can use it promptly, it may be a good buy.

17. Even bread and cereal offer a choice. Loaves of bread are generally the best buy, rather than rolls or crackers. Consider whether you can use day-old bread, which is usually sold at reduced prices. Cereals that require cooking, such as oatmeal, are cheaper per serving than ready to eat cereals. Select the quick cooking varieties for maximum convenience and economy. Be sure to buy enriched bread, and vary your routine with whole wheat or other dark varieties from time to time.

18. Butter or margarine? Margarine that is fortified is nurtitionally a good substitute for butter and yet may cost less than half as much. Use it where you can if your budget is important. Remember, you can use leftover drippings for a variety of cooking purposes, so save beef and bacon fat if you want to make this saving too.

Handout 4: Check Sheet on Cooking Hazards

Do you?

NO YES

( ) ( ) 1. Keep pot and pan handles positioned toward back of stove?

( ) ( ) 2. Avoid clothing with long flowing sleeves that may easily catch on pot handles and/or cause burns?

( ) ( ) 3. Clean up spills on floors immediately to prevent falling?

( ) ( ) 4. Avoid broken or chipped cooking utensils or serving pieces?

( ) ( ) 5. Turn off the range and oven when not in use?

( ) ( ) 6. Check electric cords on appliances periodically for worn places? Replace if necessary?

( ) ( ) 7. Avoid overloading electric outlets? Unplug those appliances that are not in use?

( ) ( ) 8. Dry hands before using electrical appliances?

( ) ( ) 9. Have gas ranges checked by gas company periodically?

( ) ( ) 10. Store knives carefully?

( ) ( ) 11. Keep a box of baking soda near the stove to use in case of grease fire?

UNIT C: MANAGING TIME, ENERGY, MONEY AND OTHER RESOURCES

ESTIMATED TIME: 3½ hours

SUGGESTED INSTRUCTOR: Home economist (may use social worker, community nurse to discuss community resources)

INTRODUCTION

This unit provides the trainee with some basic concepts of time and energy conservation that may be applied to both personal and service activities. It should provide an understanding of the use of individual, family and community resources and the related responsibilities of the homemaker-home health aide.

EXPECTED OUTCOME

The trainee will be able to:

- Identify ways to conserve time and energy while providing services
- Identify resources within the family
- Identify what resource management responsibility may be expected of the homemaker-home health aide
- Describe community resources available to individuals and families.

CONTENT

Part 1: Role of the Homemaker-Home Health Aide in Time and Energy Management

This part will discuss time and energy management. The homemaker-home health aide needs to know how to make wise use of time and energy.

The responsibilities of the agency and its homemaker-home health aides include tasks essential to family living. Good family living involves management of time, energy and resources. Used wisely, they help people enjoy home and family living. But time and energy management should be regarded as a means, not an end in itself. In homemaker-home health aide services that would mean that the needs of the person served should not be ignored by the homemaker-home health aide who is eager to get tasks done quickly and with the least effort. For example, the homemaker-home health aide may have planned to vacuum but the elderly and partially disabled family member, who needs exercise, asks for your assistance in taking a short walk on a nice day. Or, a small child needs the homemaker-home health aide's help while he/she is in the middle of dishwashing. Is it more important to finish? The needs of the person being served must be the homemaker-home health aide's first consideration. This is a principle to be remembered in all tasks.

The work of the homemaker-home health aide involves the use of time and the expenditure of both physical and mental energy. The amount of time available to accomplish a given amount of work is usually indicated in the plan of service for the individual and family. The use of the allotted time and the expenditure of energy in accomplishing the tasks and resulting fatigue depend on how well the work is organized. It is also of concern to the recipient of service. When time and energy are used wisely and effectively, work is planned and coordinated with a minimum amount of disruption of the family routine. It is especially important in teaching the family how to maintain the home and still have time for those activities which it values and enjoys. The community and agency benefit from services that are provided in an effective and economical manner.

There are three ways of dealing with time. These are:

- Conservation means short cuts that can reduce the time spent on ordinary tasks, especially in those activities done repeatedly - rinsing and stacking breakfast dishes to be washed with others once a day

- Control means the efficient approach to what is to be done - scheduling and planning the use of time by the week or month rather than by the day

- Extra means time available that allows overall planning and allowing for recreation and special activities such as taking a walk with the person receiving service, baking cookies for the children, or making personal arrangements to take a class.

Exercise 1 and Handouts 1 and 2 may be used in discussing the effective use of time.

Energy conservation is closely related to the use of time and includes physical energy (use of the body) and the movement involved in performing a task. The homemaker-home health aide will be less tired and less likely to incur strains and injury if the body is used correctly. Using the right muscles for an activity is called body mechanics. *(See Handout 5, Unit A of this Section Body Mechanics in Cleaning and Maintenance.)*

Because all people have different physical and mental peaks, it is important for the homemaker-home health aide to know when peaks occur. It is not always possible to plan accordingly, but recognition of the fact may increase the level of performance and avoid fatigue.

Activities may be classified into three categories; those that must be done immediately, and why, those that can be done within a certain time period, and those that would be nice to do if there were time. Time should be spent where it counts. It is important to think in terms of quality use of time as well as quantity. This may be especially significant in teaching and in meeting the special and immediate needs of persons and families. A good test is to ask oneself how much time is expended with what amount of energy to what purpose.

Energy and time are also conserved by simplifying tasks. This means analyzing a task carefully by noting each movement required to accomplish it. Tasks should be broken down into steps: those that are required in preparation, the movements used in performing the task and the requirements for cleaning up. These steps should then be analyzed as to purpose and timing, with special note of what movements could be eliminated, what movements could be combined and how the work could be made easier. *(Exercise 2 and Handout 2 may be used for discussion.)* Good work habits are the result of effective management of time and energy.

Part 2: Use of Resources

It is important that the trainees understand and help individuals or families to use their own resources when confronted by problems.

There are many resources, often untapped, available to a family. They may exist within the family itself or within the community; they may be human or material. How often in times of parental illness have the children in the family rallied in terms of meal preparation, cleaning, etc.? Or when financial resources are scarce, that unrecognized talents come to the fore in do-it-yourself projects? An important part of homemaker-home health aide services is to draw upon the family and the family support system to the extent possible before community resources are sought. Such efforts strengthen the family's independence and its involvement in the care of family members.

However, many families needing homemaker-home health aide services may also need other community services. The recommendation for use of these resources will be included in the plan of care. It is important that the homemaker-home health aide be aware of these services. *(Exercise 3 may provide a guide for discussion of community services.)*

To familiarize the trainee with relevant, local services, a discussion by an information and referral specialist or a panel of agency representatives may be used. The panel might consist of agencies representing social services for families and children, health services, food services, including food stamps, counseling centers, and churches, etc.

This discussion of community services should include the following facts:

- Kinds of services available, including free and non-free services
- Eligibility requirements to obtain services
- Procedures for obtaining services
- Referral time involved - time required to obtain, length of time service may be used
- Cost of non-free services
- Location of services - specific address, telephone number, and contact person
- Method of delivery of services.

Part 3: Money Management

This part discusses how to help families make use of money.

The wise use of money involves knowing how money will be spent, before it is spent. Helping the individual or family to set priorities regarding needs and financial expenditures is often an important part of homemaker-home health aide service. This includes a respect and consideration of family values.

Values are important to people and influence their actions. Values differ from one person to another, influence the way money is spent, and help to determine goals.

Goals are the ends toward which an individual or family direct their activities. They may be short- or long-term. Family goals affect the way families spend their money. When goals are realistic, they are more likely to be met. Realistic goals are determined by assessing the resources available to the family -- money, energy, talents and skills. *(Exercises 4, 5, 8, 9 may be used to illustrate how values affect goals and spending.)*

Most families find that they must make choices about how they spend their money. Basic needs of food, clothing and shelter must be met first, to the degree that these are important in the family's value system. If there is money left over, it can be used to buy the things the family wants. Sometimes members of the family want different things and difficult choices must be made. Usually those things which will benefit the entire family will be.purchased, but not necessarily. Family participation is important in this process, which usually involves long- and short-term goals. Expensive music lessons for a talented child may eventually enhance the family functioning.

When money is limited, it is critical that what is purchased is really what is wanted and the best value for the money. Therefore, it is important to know the best time to make certain purchases, how to distinguish poorly made articles from quality merchandise; how to comparison-shop for all purchases, ways of taking advantage of special sales and featured items at the food market, and how to avoid impulse buying, e.g. by sticking to the shopping list. A homemaker-home health aide may often be asked to help a family learn how to shop and use money wisely and effectively to meet needs. *(Exercise 7 and Handout 3 may be used in discussing budgeting.)*

The agency may be asked to assume responsibility for managing money resources. This responsibility is only taken when it is specifically requested or there is no reasonable alternative. The plan of care developed by the family and care team will guide the homemaker-home health aide in activities relating to the use and management of money. One example may be that of shopping for an elderly or disabled person who is unable to leave the house or whose energy does not permit shopping. This requires that the homemaker-home health aide have some knowledge of the family's financial resources. It also involves handling money and the careful selection of purchases. It is important that the homemaker-home health aide keep all receipts, count out change to the person assisted in this way and develop a responsible system for accounting for all money spent. This is a particularly delicate area when working with the elderly person who becomes forgetful. *(Handout 4 may be used as a sample receipt form.)*

AIDS

Exercise 1: Time-Saver Checklist

Exercise 2. The 5-Step Plan for Work Simplification

Exercise 3. Community Resources

Exercise 4. How Values Affect Your Life

Exercise 5. How Goals Affect Spending

Exercise 6. Skills As An Individual and Family Resource

Exercise 7. Budgeting and Resource Management Assistance

Exercise 8. The Singing House

Exercise 9. Families and Their Values

Handout 1: Suggestions for Improving Use of Time and Energy

Handout 2. Improve the Way You Work

Handout 3. Income Sources

Handout 4. Sample Receipt for Expenditure of Money

Exercise 1: Time-Saver Checklist

Directions:

Answer the questions which follow either yes or no in the space provided. If there are differences of opinion, regard such answers as negatives.

Yes	No	Questions
___	___	Do I think ahead -have my schedule so well in mind I don't have to spend time wondering what to do?
___	___	Do I act promptly - not lose time deciding whether to do a task now or later on?
___	___	Do I have a place for everything - know where to locate things quickly to avoid losing time looking for something?
___	___	Do I concentrate on one thing at a time - not let distractions enter in to slow me down?
___	___	If possible, do I finish my work once I start it - avoid the delay of having to pick up where I left off?
___	___	Am I a careful worker - do things efficiently the first time and not waste time and energy doing them over again later on?
___	___	When I finish a job, do I put the used materials away - know that it takes less time to start on a new task when things are orderly than when things are cluttered?
___	___	Do I have a desirable attitude toward doing things which have to be done - realize time passes more quickly when a task is enjoyed, and drag when it is disliked?

Number of questions answered by Yes: ____

Number of questions answered by No: _____

Comparing your total number of Yes answers with your No answers should give you an idea of your need to know more about time savers and how you can use them.

Exercise 2: The 5-Step Plan for Work Simplification*

A. Select the job to be improved:

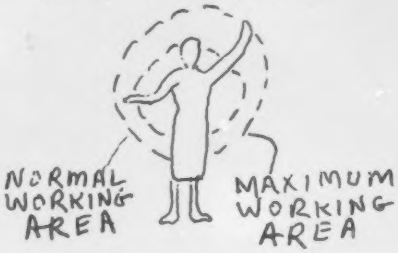
(One which you feel takes too long, makes you too tired, or uses up too much energy.)

B. Break down the job operation:

(List all details exactly as you do the job at present.)

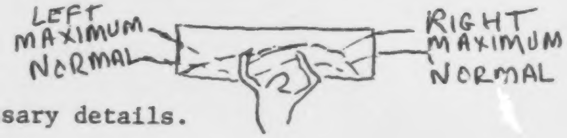
1) Get ready: collection of tools and equipment.
2) Do: bodily motions you use to do the job.
3) Clean up: the cleaning and putting away of equipment.

C. Question the job and equipment:

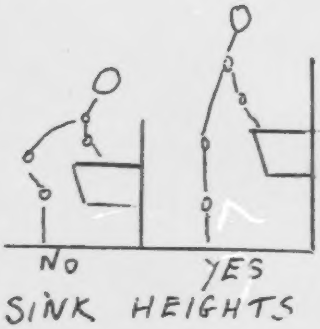


1) WHY is it necessary?
2) WHAT is the purpose?
3) WHEN should it be done?
4) WHERE should it be done?
5) HOW is the "best way" for me to do it?

D. Develop the new method:



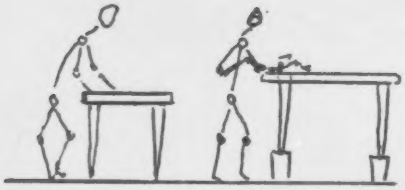
1) Eliminate unnecessary details.
2) Combine motions and activities.
3) Rearrange sequence of job.
4) Simplify all necessary details:

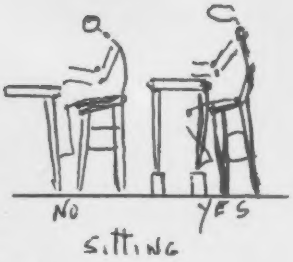


a) Make work easier with correct counter height and normal work areas:

- Correct counter height for standing (as sink) should be 2 inches less than the distance from the floor to your elbow
- To find the proper height for your work chair, measure the distance from your elbows to the floor while you stand and also while you sit. The distance from floor to elbow when you stand, minus the distance from floor to elbow when you sit equals the amount to be added to the present height of chair. HOW? Like this Chair
  Block of wood Leg

Exercise 2 (continued)





b) Pre-position equipment in work areas (the point of first use)

c) Use gravity feed drops (sugar, flour)

d) Use feet whenever possible (opening and closing cupboards, etc.)

e) Make motions simultaneous and productive. Use both hands, arms

f) Use smooth continuous motions -- no jerking.

E. Apply new method:

1) Rearrange tools and equipment

2) Readjust working heights and areas

3) Set up working areas:

   Dishwashing area
   Cooking area
   Mixing area
   Storage area
   Rest area (relaxation)

4) Throw away things you don't use (unclutter).

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* American Heart Association, 44 East 23rd Street, New York. Take it Easy! #2.

Exercise 3: Community Resources

This exercise will focus on identifying persons and/or agencies that should be contacted on an ongoing basis.

Identify persons or agencies relative to the following case situations:

- Member of family is partially sighted and wants some large-print materials for reading
- Family member needs to use public transportation system occasionally but does not know how
- Family wants some grocery delivery services
- Family wants occasional help with lawn mowing, other yard work; does not own equipment
- Member of family needs medical or dental care, does not have insurance and can't afford regular channels or use of these services
- Person living alone not able to provide adequate meals for self when homemaker-home health aide is not there
- Needs assistance in completing some insurance forms, but cannot affort to hire a lawyer.

Discuss the homemaker-home health aide's role in identifying need for and securing services.

Exercise 4: How Values Affect Your Life

Trainees may use the following exercise in identifying how values influence their own goals and spending as a basis for better understanding those of others.

List four values of importance to you and members of your family.

Set some long-term and short-term goals for family spending which are based on the values you listed.

Rank your values in order of importance. Is this difficult to do? Why? Are these the same values that were important to you ten years ago?

Do some of the individual goals of your family members conflict with other goals?

Exercise 5: How Goals Affect Spending

This exercise illustrates how values affect goals and spending. The trainees should be asked to add other goals and values and possible effects on spending.

Values	Goals	Spending
Home	Down payment on house	Reduce other expenses
	Furniture	Go without new clothes
Health	Regular visit to doctor and dentist	Buy black and white instead of color TV
	Health insurance	Go without new furniture
Family	Money for birthday present for child	Father goes without haircut to provide
Education	Funds for school supplies	Mother works to provide this
	Money for father to night school to get diploma	Drive old car another year
Security	Life Insurance	Reduce recreational expenses

Exercise 6: Skills As An Individual and Family Resource

List skills that might help a family save money. The following may be used as major headings:

- Skills in food preparation
- Skills in maintaining and use of clothing
- Skills in housekeeping.

Exercise 7: Budgeting and Resource Management Assistance

This exercise was developed to assist trainees in identifying resource management and budgeting principles and exploring ways of improving other peoples' budgeting skills.

Ask the trainee to suggest potential budgeting or resource management problems that individuals and families might have.

List here on a board or flipchart using the heading below:

Potential Problem	Potential Remedial Actions	Homemaker-Home Health Aide's Role and Knowledge Needed
Individual/Family		
Example: Lack of planning grocery buying		

Ask the trainees to describe possible remedial actions. Try to elicit several alternatives.

Have the trainees describe the potential role of the homemaker-home health aide in these situations and what type of knowledge would be required.

Discuss such areas as:

What is a budget?

Why should budgets be used?

How do people feel about money and budgeting?

What are the responsibilities of each family member?

Exercise 8: The Singing House

This exercise will emphasize alternative ways people value and use money.

Have the trainee read aloud "The Singing House."

Discuss:

- Differences between Fred's family and Jimmy's family in way they use money
- The differences in values that led the two families to use money differently
- Examples of persons the trainees know who use money differently from the way the trainees do. Emphasize that:
  - homemaker-home health aides do not give personal opinions and unasked for advice to families about money use
  - a family's values are important in determining money use
  - when homemaker-home health aides are involved in the use of family's money -- through shopping, recommending purchases, etc. -- they are obligated to use money responsibly and to keep records.

The Singing House*

I tied the napkin around Fred's neck and placed before him his glass of orange juice, his cereal, his big glass of foamy milk. In my own opinion, I was classified among the superior mothers whose children are brought up in the approved manner of an enlightened day.

Fred ate it all dutifully and then slipped down from his chair.

"Now can I go over to Jimmy's, Mother?" he asked.

"But, Fred, "I remonstrated, "you were over there yesterday and the day before. Why not have Jimmy come here, today?"

"Oh, he wouldn't want to." Fred's lip quivered in spite of his six years of manhood. "Please, Mother."

"Why do you like Jimmy's house better than ours, Son?" I pursued. It came to me suddenly that Fred and all his companions were always wanting to go to Jimmy's house.

The Singing House (continued)

"Why," he explained hesitatingly, it's 'cause..., it's 'cause Jimmy's house is a singing house."

"A singing house?" I questioned. "Now what do you mean by that?"

"Well," Fred was finding it hard to explain. "Jimmy's mother hums when she sews; and Mrs. Knight-in-the-kitchen, she sings when she cuts out cookies; and Jimmy's daddy always whistles when he comes home." Fred stopped a moment and added, "Their curtains are rolled clear up and there's a lot of flowers in the windows. All the boys like Jimmy's house, Mother."

"You may go, Son," I said quickly. I wanted him out of the way so I could think.

I looked around my house. Everyone told me how lovely it was. There were Oriental rugs. We were paying for them in installments. That was why there wasn't any Mrs. Knight-in-the-kitchen here. We were paying for the overstuffed furniture and the car that way, also. Perhaps that was why Fred's daddy didn't whistle when he came into the house.

I put on my jacket and went over to Jimmy's house, even if it was ten o'clock on Saturday morning. It came to me that Mrs. Burton would not mind being interrupted in the middle of the morning. She never seemed to be in a hurry. She met me at the door with a towel around her head.

"Oh, come in. I have just finished the living room. No indeed, you are not interrupting. I'll just take off this head-dress and be right in."

While I waited, I looked around. The rugs were almost threadbare; the curtains were faded, ruffled and tied back; the furniture, old and scarred but freshened with new cretonnes. A table with a bright cover held a number of late magazines. In the window were hanging baskets of ivy and wandering jew, while a bird warbled from his cage hanging in the sun. Homey, that was the effect.

The kitchen door was open and I saw Jerry, the baby, sitting on the clean linoleum, watching Mrs. Knight as she pinched together the edges of an apple pie. She was singing, singing, "Springtime in the Rockies."

Mrs. Burton came in smiling. "Well, she asked, "what is it? For I know you came for something. You are such a busy woman."

"Yes," I said abruptly, "I came to see what a singing house is like."

Mrs. Burton looked puzzled. "Why, what do you mean?"

"Fred says he loves to come here because you have a singing house.

I begin to see what he means."

"What a wonderful compliment!" Mrs. Burton's face flushed. "But of course my house doesn't compare with yours. Everyone says you have the loveliest house in town."

"But it isn't a singing house," I objected. "It's just a house without a soul. Tell me how you come to have one."

"Well," smiled Mrs. Burton, "if you really want to know. You see, John doesn't make much. I don't think he ever will. He isn't that type. We have to cut somewhere, and we decided on non-essentials. I am not very strong and when Jerry came we decided Mrs. Knight was an essential if the children were to have a cheerful mother. Then there were books, magazines, and music." She pointed to the radio. "These are things the children can keep inside. They can't be touched by fire or reverses so we decided they were essentials. Of course good wholesome food is another essential, but we don't buy things out of season, and our bills are not large. But when all these things are paid for, there doesn't seem to be much left for rugs and furniture. But we find we get almost as much pleasure from our long country walks, with Jerry in his stroller, as we would in a car, especially if we had to worry about financing it. We don't go in debt if we can avoid it. Moreover, we are happy," she concluded.

"I see," I said thoughtfully. I looked over at Jimmy and Fred in the corner. They had manufactured a train out of match boxes and were loading it with wheat. They were scattering it a good deal, but wheat is clean and wholesome.

I went home. My Oriental rugs looked faded. I snapped my curtains to the top of the windows, and the light was subdued as it came through the silken draperies. The over-stuffed sofa looked bulky and not nearly so inviting as Mrs. Burton's old daybed with pillows you were not afraid to use. I hated my house. It didn't sing. I determined to make it sing.

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* Reprinted from Child Welfare Magazine. State of Wyoming.

Taken from: Resources and You. Bulletin No.400 G-14. Cooperative Extension Service, New Mexico State Univeristy, La Cruces, New Mexico: February 1975.

Exercise 9: Families and Their Values

The Garden Grove Housing Units are located in the northern part of a middle-sized city in Texas. Three families, the Browns, the Allens, and the Martins, all live in this unit and have approximately the same incomes. Their housing and food expenses are similar. However, their other expenses vary considerably.

The Browns own a color TV set, often go for short drives on the weekends, and attend many football and basketball games. Jimmy Brown has poor teeth but there seldom seems to be enough money for dental bills. The family seldom buys any furnishings for the home and they have no savings.

The Allens have a small savings account to which they try to add money monthly so their son can go to a vocational school to study auto mechanics when he finishes high school. They are now buying a set of reference books on the installment plan for the younger children in the family. They have a black and white TV set and spend many evenings watching TV programs. Mrs. Allen would like a new rug, but at the present time they cannot afford one.

The Martins like to fix things, so they spend a great deal of time refinishing inexpensive pieces of furniture and have just finished painting their apartment. Their most recent purchase was a new chair for the living room. Susie Martin wants a new dress for the next school dance, so the family is trying to figure out how they can afford this. After they make their contribution to the church this week, there will be little money left until the next paycheck.

Ask the trainees to identify:

1. The differences as to how the Browns, Allens and Martins spend their money.

2. The values and goals that influence how they spend their money.

Handout 1: Suggestions for Improving Use of Time and Energy

1. Save energy by sitting to do task when possible.

2. Use principles of body mechanics to avoid body harm and possible loss of time and energy.

3. Use both hands as often as possible.

4. Assemble all tools and materials needed for a task before starting. This eliminates trips while doing the task.

5. Make sure areas for work are uncluttered and well lighted.

6. Plan each item needed from a store so as to avoid making extra trips.

7. Keep traffic areas clear to avoid extra steps in walking around things.

8. Store things used frequently in places that are easily accessible.

9. Use trays, carts, baskets to carry several things, removing dishes from the table and baskets to carry laundry.

10. Use the right tool for a task; for example, a vegetable peeler is quicker than a knife.

11. If there are stairs in a house, do as much as possible when upstairs to avoid making many up and down trips.

12. Do tasks in such an order that they do not need to be redone (for example, straighten furniture as you vacuum, not before).

13. If space is available, prepare often used food items ahead of time and freeze or store for quick use.

14. Consider how you might change the menu to save preparation time.

15. If oven is being used, try to cook more than a single item in it to save energy and time.

16. Encourage family members to do things for themselves and to assist in household tasks such as hanging up clothes and rinsing the bathtub after use.

17. Take a few moments early in the day to go over the day's tasks mutually or on paper. Reorganize as needed.

18. Arrange a schedule according to the frequency with which tasks are to be done: monthly, weekly, or daily.

19. Take occasional breaks and rest a few moments to restore energy. Relaxing is not a waste of time.

20. Take pleasure and pride in the well-done job. This can add much to the energy level.

21. Eat the right foods. A proper diet provides energy as well as maintains the body. Food contributes to the feeling of well-being and productiveness.

22. Keep yourself looking neat. People feel more like working when they are dressed properly.

23. Do not wear clothing that slows down work. For example, sleeves which have to be pushed up constantly or a skirt that prevents easy walking.

24. Stop and think about how a task could be made easier. Although it may take a few moments, time and money may be saved in the long run.

25. Alternate tasks that take a short time and those taking a long time.

26. Alternate tasks that require a lot of energy and those that are more relaxing and require less energy.

27. Procrastinating wastes time: plan what is to be done and do it.

Handout 2: Improve the Way You Work

Work is more fun if you use the easiest way that gets good results. How well do you use these six working methods?

1. Use both hands -- examples:

   Use a dust cloth or mitt in each hand as you dust furniture.

   Take dishes from a cabinet with both hands and place on tray.

   Use both hands in setting a table.

   Ideas of your own:

2. Place your work within each reach -- examples:

   Take all tools and supplies needed to the room to be cleaned before cleaning.

   Assemble utensils and supplies needed for preparing food before beginning.

   Ideas of your own:

3. Eliminate things that do not need to be done:

   Air-dry dishes instead of drying them with a cloth.

   Use synthetic detergent in bathtub to prevent bathtub ring.

   Ideas of your own:

4. Combine jobs when possible -- examples:

   Use furniture polish that cleans as it polishes.

   Use a cleaner that cleans and disinfects.

   Ideas of your own:

5. Make full use of tools and work materials -- examples:

   Use vacuum cleaner for all dusting.

   Use utility cart or tray for carrying several small items.

   Ideas of your own:

Handout 2: (continued)

6. Maintain good posture and use muscles properly -- examples:

   Use leg muscles rather than back muscles when lifting.

   Use easy, free rhythmic motions in sweeping, dusting and similar tasks.

   Ideas of your own:

Handout 3: Income Sources

Sources of Income	Monthly Amount	When Received
Wages (take-home pay) Father Mother Children		
Social Security		
Unemployment Insurance		
Welfare Payments		
Aid to Dependent Children Payments		
Other		

TOTAL

Handout 4: Sample Receipt for Expenditure of Money

HOMEMAKER-HOME HEALTH AIDE SERVICE

____ Homemaker-Home Health Aide received $__________________ for the purchase of ____.

She purchased $____________ worth of ____________________________ (see cash register receipt). $__________________ of charge was returned to me.

____
Signed

____
Address

____
Date

Received at Homemaker-Home Health Aide Agency____________________
Date

SECTION IV

PRACTICAL SKILLS AND KNOWLEDGE IN PERSONAL CARE

The Section on personal care continues the instruction in practical skills. These skills relate to observing, helping with bathing, grooming, exercises and simple treatments for the sick, elderly and disabled in their own homes. Services may involve the care of the very ill, even dying person, the severely handicapped and those needing only minimum assistance with grooming. The Section is based on the understanding of working with people and their special needs as described in Section II. It may be helpful to start with a brief review of the general needs of people (Unit B) and the needs of the ill and disabled (Units E and F). A minimum of 19 1/2 hours is suggested. However, when additional procedures are added, additional hours must also be added. The trainees should have an opportunity to practice the skills. This Section should be taught by a professional nurse, preferably a community nurse who is familiar with home care and homemaker-home health aide services.

UNIT A: THE HUMAN BODY

ESTIMATED TIME 2 hours

SUGGESTED INSTRUCTOR Professional nurse or physician

INTRODUCTION

This unit provides information about basic anatomy and physiology as it relates to functions of the body. The information provides the normal basis for the homemaker-home health aide to observe changes in the person and to apply knowledge of the body in the application of personal care skills.

EXPECTED OUTCOMES

The trainee will be able to:

- identify the basic body systems as a basis for giving personal care
- identify body functions as these influence the application of personal care skills

MATERIALS AND EQUIPMENT

Audio-visual aids, wall charts, models, slides, or films of the digestive, circulatory, nervous, urinary, respiratory, skeletal-muscle and reproductive systems.

CONTENT

The first topic to be covered is body systems and functions. The following overview of body systems will be enhanced by the use of slides, films, anatomical charts or models.

Knowledge about body systems and functions provides a basis for understanding changes that may occur when a person is ill.

Point out the body parts and functions as the systems are discussed.

Bring out points about how personal care helps maintain functions of the body.

The human body is made up of a very intricate network of cells, tissues and organs. All of these are designed to work together in systems to help the body function properly.

The simpler unit, the cell, is composed of tiny living parts. These major parts are the nucleus, cytoplasm and plasma membrane. The nucleus and cytoplasm accomplish complex chemical actions within the cell to nourish the cell, to reproduce another cell, or to maintain its particular function. The plasma membrane helps in the transport of substances in and out of the cell.

A group of cells with similar functions may form tissues. Four of the major types of tissue are muscle, nerve, epithelial (which forms glands or surface covers), and connective tissue (cartilage, tendons, fat).

Various types of tissue form organs. An example is the heart. The heart is made up of tissue that performs a specific function (circulates blood throughout the body). Other organs perform other functions, such as the stomach, which digests food.

Several organs make up a body system. One example is the digestive system. It is made up of the alimentary canal (the "tube" starting at the mouth and ending at the anus), the glands for digestion, the liver, the gallbladder and the pancreas.

(The following paragraphs are simple, introductory descriptions of the various body systems. After assessing the class needs, the instructor may wish to go into greater depth.)

The Skeletal System

Over 200 bones and joints provide a bony frame for the body. This frame protects the body, gives some leverage when moving and provides an anchor for muscles and tendons. Parts of the bones also produce red blood cells, white blood cells and platelets. Bone which is connective tissue has calcium and potassium salts in it which make it hard. A joint is the meeting of two or more bones, which has a covering around it and is strengthened by cords called ligaments. Bones, joints and ligaments are attached to each other to help the body move and maintain good posture and alignment of the skeletal system.

In giving care to a person who has a break in a bone, who has a ligament pull or sprain, it is important to remember the concept of the bony system as forming the frame for the body. Limbs must be moved carefully and joints supported underneath. Doctor's orders and the care plan indicating the amount and type of activity must be followed carefully.

Older adults often need more time to move about than younger people. In addition, older persons' bones tend to be more brittle, especially in older women. Use caution in assisting patients. Be alert to obstacles and remove any obstructions over which the person may fall.

The Muscular System

There are over 300 muscles in the body. There are two types of muscles--voluntary and involuntary. Voluntary muscles are attached to bones and give shape to the body. In addition, these muscles provide strength and help parts of the body move. Body heat, which the body needs, is produced when voluntary muscles move. In order for these muscles to move, a command to move must come from the brain. The second type of muscle is involuntary. An example is the muscle of the heart. The heart muscle moves as it contracts and squeezes blood out into the arteries. This is an involuntary or "automatic" action that does not require a command from the brain.

For maintaining healthy function of the muscular system good posture is essential. When personal care is given to a person with a muscular problem, the type of care may be similar to that given the person with a skeletal problem. For example, activity orders must be followed carefully. The person must be moved cautiously and given support to each joint as a limb is moved. Treatments may be ordered for sprains or swollen limbs. A cold pack may be applied for these conditions. Or, hot packs may be ordered for soreness, inflammation or infection. In caring for a person who is restricted to the bed, the rotation of joints and movement of muscles (called range-of-motion exercises) may be included to keep the muscles in good tone and the joints from stiffening.

The Skin

The skin provides a cover for the muscles, bones, organs and other tissues. The functions of the skin include protection of internal organs and structures, removal of waste products through the pores (tiny openings in the skin), absorption of substances, and regulation of water loss and body temperature.

Good personal care should always include good skin care. Good skin care includes bathing and massaging body parts. Bathing removes the waste products on the skin's surface and keeps it as free from germs as possible, which helps to reduce infections. Bathing also helps the person feel better about himself and has esthetic value. Another important reason for personal care is to reduce the chance of developing pressure sores, particularly in older and very thin persons. (This is discussed in more detail in the Section on Care of the Person in Bed.) The possibility of pressure sores may be reduced by stimulating the circulatory system through the motion of bathing and/or massaging the skin. The well person should practice good skin care for the same reasons.

The Circulatory System

The heart, blood vessels, and lymph nodes and vessels are considered part of the circulatory system. Sometimes the spleen and thymus are included. The main function within this system is the pumping of blood by the heart, located under the breast bone and slightly to the left, to all parts of the body, including the tiny cells. The purpose is to bring dissolved nutrients, oxygen, hormones, antibodies and blood clotting factors to the cells, and to remove waste products from the cells. The circulation of blood also helps to keep the body at an even temperature and balance the fluid and acid-base level.

Within this system, the lymph is moved along the lymphatic vessels by valves that open in one direction. Lymph helps to remove the larger protein molecules from the tissue spaces and helps to reduce swelling or edema. Lymph passes first through the lymph nodes that serve as filters before the lymph empties into large veins at the base of the neck. This keeps foreign material and germs from entering the bloodstream. Lymph nodes may be felt in the neck, groin and in the armpits.

The spleen, located over the left upper side of the abdomen, also filters the blood much in the manner that lymph nodes filter the blood. In addition, it produces white blood cells to fight infection. It stores blood and iron; iron helps in red cell metabolism and it produces antibodies which are important in fighting infections.

The thymus, situated in the upper chest, also produces and stores white blood cells.

Good circulation is vital to health. Cells, tissues, and organs do not function well if the circulation is inadequate. For example, a person with poor circulation may have trouble breathing, digesting food or with kidney function. The circulatory system provides the lifeline for the entire body. The vital signs, that indicate the "vitality" or "life" of the body are obtained by taking the temperature, pulse and respiration. Blood pressure is another vital sign that demonstrates the condition of the circulatory system. Vital signs are taken often when a person is ill to indicate the state of the person's health.

In taking care of a person, the homemaker-home health aide needs to be aware that exercise increases the heart beat and circulation, while sleep and rest slow the heart beat and allow other organs to slow down. This is an important concept to remember when energy should be used for the healing of the body. Exercise, as stated before, should be done according to the care plan.

The Respiratory System

Included in this system are the lungs and passages leading to and from the lungs (nose, windpipe) and the muscular diaphragm. Two functions of respiration are to breathe in air from which the blood picks up oxygen and to breathe out air which has in it waste products, carbon dioxide and water. The diaphragm helps in the inhalation and exhalation of air. The lungs hold approximately three and a half quarts of air. If the lungs are diseased, the body cells do not receive the oxygen needed for maintaining healthy cells, waste products are not removed efficiently and other parts of the body do not function as well. As much as possible, persons should avoid polluted air, and smoking is considered hazardous to health, especially for the respiratory system.

In giving personal care to a person with respiratory problems, it is important to follow specific treatments recorded in the care plan. These may include deep breathing exercises, coughing routines, inhalation of medications and observing the person's respiration at given times. The person who has difficulty breathing may need more time to complete simple everyday activities such as dressing and eating. The person may be more comfortable in a sitting position, which helps him breathe more easily.

The Digestive System

This system includes all organs that function in digesting food. These are the mouth, tongue, salivary glands, teeth, pharynx, the esophagus, stomach, small and large intestines, rectum, anus, liver, gallbladder and pancreas. One function of the digestive system is to break down food into small enough particles to be absorbed into the blood and nourish all cells of the body. Another function is the removal of food wastes through the intestines, rectum and anus.

The stomach, located in the left upper- and mid-abdomen, churns food mixed with a liquid called gastric juice. Small amounts of mixed food move into the small intestine until the stomach contents are emptied, which takes three to five hours. Carbohydrates and proteins are broken down into small food particles by juices from the pancreas. Almost all absorption of food occurs in the small intestine. (The small intestine has small, finger-like projections called villi which absorb these small food parts into the blood.) The waste products include undigested food, germs, mucus and water. The wastes are called feces and are passed out of the body through the anus.

The pancreas, located in the mid-abdomen, produces insulin and helps in the metabolism of sugar and produces digestive enzymes. The liver, located along with the gallbladder in the upper right abdomen, stores sugar, minerals, vitamins, forms of protein and fat and removes harmful substances from the blood, such as drugs and alcohol. The gallbladder stores and concentrates bile that helps break down fats.

Because it helps maintain body nourishment, the digestive system is important to health. Therefore, when giving care the aide should be aware of conditions that indicate that the system is not functioning and help the person to follow carefully his prescribed diet. A nourishing diet is necessary to repair tissues and to maintain a healthy body.

The Nervous System

The brain, spinal cord and nerves are all part of the nervous system. The sense organs may also be considered as part of this system (eyes, ears, taste buds and organs of smell and touch). The nervous system may be thought of as a message center. Contacts with the outside world and internal impulses are carried to the brain by the nerves and sent to the body for action.

The brain is made up of nerve cells and nerve fiber. Parts of the brain deal with memory, thinking, judgment, emotion, body movement and speech. The stem connecting the brain and spinal cord acts to transmit the impulses.

The spinal cord is located within the backbone (vertibral column) and carries messages to and from the brain to the body so the body can react. Fluid fills spaces in the brain and the coverings of the spinal cord (meninges), which helps to protect the brain and cord from pressure or injury.

The nervous system is another important system and must function well for the body to function properly. Whenever an impulse cannot be carried properly, as with a stroke, changes in function of the body may result, such as slurring speech and/or loss of movement on one side of the body.

The Urinary System

Included in this system are the organs that remove waste products from the body in the form of urine. The urinary system consists of two kidneys, located in the small of the back; two ureters, which lead from the kidney and carry urine to the bladder; the bladder, located in the lower pelvis; and the urethra, which drains urine from the bladder. The urinary sphincture releases the urine on command. The kidneys help maintain the body's water balance, filter the blood, and remove waste products. Approximately one and a half quarts of urine are excreted daily, depending upon the amount of perspiration and fluid intake.

When the kidneys do not adequately remove wastes from the body, the person may experience a generalized feeling of illness. The person may have swelling or puffiness (edema) and have a grayish skin tone. Life cannot be maintained without some way to adequately remove body wastes from the blood. In giving care, it is important to see that the person takes plenty of fluid to help remove body wastes and toxins. When kidneys fail to function, or function inadequately, wastes may be removed by the use of artificial means, by renal dialysis, sometimes referred to as kidney machines.

The Reproductive System

This system consists of the external and internal sex organs of the male and female. The male organs include the scrotum, a sack-like organ that contains the testes and other tubules; the testes, that produce sperm, the hormone testosterone and fluid; the penis, that contains the urethra for transporting urine and sperm; the prostate gland, located below the urinary bladder, that produces fluid to help transport the sperm.

The female external organs are the genitalia and breasts. The internal organs include the vagina, which functions as the birth canal leading to the cervix and uterus; the cervix, that is the mouth of the womb; and the uterus, located behind the urinary bladder (the uterus functions as the womb that receives the fertilized egg and developing fetus); the ovaries, located on either side of the lower abdomen, which produce estrogen and progestrone hormones and egg cells; and the fallopian tubes that carry the egg cells from the ovaries to the uterus. The female has a menstrual cycle approximately every 28 days by which the uterus is prepared to nurture the fertilized egg into a viable fetus. However, if the egg cell that is produced in mid cycle is not fertilized by the sperm cell, the uterine lining is sloughed off and bleeding occurs for approximately three to five days.

The reproductive system is important in maintaining the sexual characteristics. The hormones, that produce male characteristics such as broad shoulders and facial, pubic, and chest hair, and female characteristics such as a round contour, enlarged breasts, and pubic hair, also are thought to help maintain functions in other systems of the body. Illness or malfunction of the reproductive system can cause emotional and physical problems for the person. It is important in giving care to treat the person with understanding and consideration and to give them opportunities to express feelings about the illness.

The Endocrine System

Organs in this system are called ductless glands. Included in this list are several organs that have also been mentioned in other systems, since they have several different functions. This system includes the testes, ovaries, adrenals, thymus, thyroid, parathyroid, and the pituitary glands. Regulation of body functions is carried out by hormones produced by these glands. If these glands do not function properly, body functions may be seriously affected. Diseases may result from an over- or under-production of hormones. For example, if the person does not have enough thyroid hormone produced, the person will feel very tired, have no energy, and may appear to be mentally slow. Too much thyroid hormone will cause the person to be nervous, overly active and jittery.

If a person is taking hormone medication, it is important that the person take such medications on a regular basis.

Although systems were discussed separately, good health depends upon the interrelated optimum functioning of the systems. Therefore, good care of the total body is essential. The aide should be aware that if one system does not function properly, it affects total body function.

SELECTED REFERENCES

Anthony, Catherine P., and Kolthoff, Norma J. Textbook of Anatomy and Physiology. 9th ed. St. Louis: C.V. Mosby, 1975.

Guyton, Arthur G. Basic Human Physiology: Normal Function and Mechanisms of Disease. Philadelphia: W.B. Saunders Co., 1977.

Malanga, Sandra C. "Your Body and How It Works." Chicago: American Medical Association, 1977.

Memmler, Ruth Lundeen, M.D., and Ruth Byers Rada, M.P. The Human Body in Health and Disease. 3rd ed. Philadelphia: J.B. Lippincott Co., 1970.

Reith, Edward J., Bertha Breidenbach and Mary Lorenc. Textbook of Anatomy and Physiology: 2nd Edition. New York: McGraw-Hill, 1978.

Thompson, Ella M., R.N., B.S., and Caroline Bunker Rosedahl, R.N., M.A. Textbook of Basic Nursing. Philadelphia: J.B. Lippincott Co., 1973.

UNIT A: ASSESSMENT

Please fill in the blanks:

1. The human body is made up of tiny units called_____________________________.
2. There are about 300 _______________in the body which help with body movement.
3. The heart, blood vessels, and lymph glands are part of the ______________ __________ system
4. The lung's capacity is approximately ______________________quarts of air.
5. The mouth, tongue, teeth and stomach are part of the______________________ system.
6. The ________________________ which is part of the digestive system, helps to remove harmful substances from the body such as drugs and alcohol.
7. The nervous system may also be thought of as a ____________________ center.
8. One method of getting rid of body wastes besides the lungs and skin is through the ____________________________.
9. Food that is eaten is mixed in the ____________________ with gastric juice.
10. The ________________ system is concerned with memory, thinking and emotion.
11. The ________________________, a part of the urinary system, helps maintain the water balance of the body.
12. The ________________________ covers internal organs and structures and helps remove waste products through its pores.
13. The reproductive system includes both external and _____________ sex organs.
14. If the lungs are not healthy, the body does not get enough ______________, for function well.
15. The ______________________ system contains a number of ductless glands, producing hormones which help regulate body functions.

ANSWERS:

1. cells
2. muscles
3. circulatory
4. 3-1/2
5. digestive
6. liver
7. message
8. kidneys
9. stomach
10. brain
11. kidneys
12. skin
13. internal
14. oxygen
15. endocrine

AIDS

Discussion Questions 1: The Human Body

Worksheet 1: Body Systems

UNIT A: DISCUSSION QUESTIONS

1. Name two functions of the skeletal system.

2. Name two functions of the skin.

3. Describe the way nutrients are taken to the cells and waste products removed.

4. Describe the function of the respiratory system.

5. Explain the process of digesting a meal and removal of waste products.

6. What important function does the urinary system have?

7. Describe the relay circuit of the nervous system.

8. Explain the main function of the endocrine system.

9. Give examples of how personal care relates to the functions of the (skeletal, muscular, respiratory, circulatory, urinary, digestive, nervous, and endocrine) body systems.

Worksheet 1: Body Systems

SYSTEM	FUNCTION	IMPORTANCE TO HOMEMAKER-HOME HEALTH AIDE
Skeletal		
Muscular		
Skin		
Circulatory		
Respiratory		
Digestive		
Nervous		
Urinary		
Reproductive		
Endocrine		

UNIT B: OBSERVING BODY FUNCTIONS AND RELATED FACTORS IN PROVIDING PERSONAL CARE

ESTIMATED TIME 3 hours

INSTRUCTOR Professional nurse

INTRODUCTION

This Unit is a follow-up of the body systems and functions unit. A base line of normal functions must be understood before body changes can be recognized and assessed. Common signs and symptoms are discussed according to systems and individual differences such as age. Signs, symptoms and the reporting of them are stressed so that care given to a person is appropriate to that person's state of wellness. The skills of taking temperature, pulse and respiration which are presented in this unit are part of observing signs and symptoms. Of no less importance is observation of the individual's environment, associations and contacts outside of the home, as these influence attitude and ultimately physical and emotional health.

EXPECTED OUTCOMES

The trainee will be able to:

- take temperature, pulse and respiration
- recognize and observe the common signs and symptoms of illness
- report and record signs and symptoms of illness and other pertinent information in a meaningful way

MATERIALS AND EQUIPMENT

- oral thermometer for each student
- large scale thermometer model
- soap and water for each student
- wipes or cotton for each student
- water soluble lubricant
- clock or watch with second hand

(American Red Cross, Vital Signs Module I: Temperature, Pulse and Respiration)

CONTENT

This Unit considers signs and symptoms of illness affecting body systems and related conditions.

Disease is an abnormal state in which the body does not function normally. The homemaker-home health aide must observe the person carefully for signs of illness and note whether the signs are increasing or decreasing in severity. It is also important to observe social, emotional and environmental conditions which may influence the person's reaction to illness and to treatment.

The homemaker-home health aide, as the primary contact person in the home, is the eyes and ears of the health care team in the important role of observing and evaluating the signs and symptoms of illness. Part of this process includes not only looking at the person but asking him questions about how he feels. Careful observation of the individual is an important part of gathering information about his health. Observations are made whenever personal care is given or whenever there is contact with the person so that changes can be noted and reported.

Each person has his own response to an illness. In addition, the age of the person may make a difference in the way he responds to illness. The onset of illness in children is likely to be fast. For example, a child may have a rapid increase in body temperature but it may also decrease rapidly. Children usually recover from an illness more quickly than older people. Children cannot always describe how they feel so the homemaker-home health aide must observe children and babies more carefully. Crying, whimpering, fussing and restlessness usually mean something is wrong and it may be a sign the child is ill. Symptoms are usually less evident in elderly persons, and the disease process may move more slowly than in younger adults. Older people may not feel pain or other symptoms as acutely as a younger person. It is, therefore, very important to carefully observe and question the older person about how he feels.

In Unit A, the human body and its systems were reviewed briefly. The following discussion relates to signs and symptoms that may be associated with each system, and may be observed by another person.

These signs may be listed on newsprint as a beginning point for class discussion. Add signs to this list as the class reviews the systems. Handout 1 should be distributed.

SIGNS AND SYMPTOMS that may be emphasized are listed below:

Skeletal and Muscular Systems: swelling of ligaments and limbs around joints; grimacing as the person moves; slow movements; bruising of the skin, or whiteness, shiny, red or hot areas over a swollen joint; loss of strength.

Skin: color changes; swelling; texture change; clamminess or moist to the touch; dry, oily, white, scaly patches; markings such as moles, scars or warts; temperature change; sores, wounds, lumps; odor; hair condition--oily, dry, dull, brittle, infestations and loss; scalp--scaly, dandruff, red.

Circulatory System: Swelling of ankles and feet, blue or white color of the nailbeds, lips, feet, or hands; swelling or hard knots in the lymph nodes of the neck, groin or in the armpit; changes in the pulse rate--faster, slower, irregular, weak or strong.

Respiratory System: Change in the rate of respiration to faster or slower; breathing--difficult, shallow or noisy; cough; types of sputum--white, yellow, odor, thick or liquid; nose--stopped up, bleeding, dry, draining; throat--sore, with red or white spots, swollen tonsils, with difficulty in swallowing.

Digestive System: Mouth and tongue--red, swollen, spotted: bad breath; diseased or bleeding gums; lined or coated tongue; cracks at the corner of the mouth. Stomach--bloated; signs of nausea or vomiting; refusal to eat or poor appetite; drinking of large amounts of fluid. Intestines--bloated; grimacing or reaching for the abdomen (cramping). Rectum--bowel movements normal, frequent, soft, diarrhea; stool--hard to move, with mucus, black, blood-tinged, or clay-colored; grimacing with pain when moving the bowels.

Nervous System: Shaking of limbs or the body; eyes--sensitive to light, dull, bright, with discharge, bloodshot, yellow color, moist or glassy; ears--with discharge, child pulling at his ear (as with pain); slowness in reacting; cannot awaken the person easily after a head injury.

Urinary System: Urine yellow, rust-colored, red, with sediment; urination frequent, difficult to start stream, small or large amount of urine with an urgent feeling to urinate, dribbling, cannot empty the bladder completely.

Reproductive System: Menstrual periods--excessive bleeding, irregular periods, grimacing with cramps; vaginal discharge--green, yellow, or white color, cheesy consistency, watery, odor; breasts--lumps, thickening, with nipple discharge, swollen, change in the contour of the nipple or breast tissue; penis discharge--yellow, green, white color; testicles--lumps or swollen.

Endocrine System: Signs will be reflected in other systems, such as increased amount of fluid intake, frequent urination, dry skin and mood changes.

Examples of behavior and/or mood changes that may be observed by the homemaker-home health aide are:

- overly critical
- irritable
- withdrawn
- demanding
- abusive talk
- crying
- aggressive
- listless
- angry
- sullen
- anxious
- depressed

(Ask the trainee to give additional mood changes. List on the flip chart or chalk board.)

Note carefully any prolonged mood change as this could be an important sign of a physical illness or early stages of an emotional illness.

The visitors and other contacts an individual may have are important in preventing a feeling of isolation and neglect, but can also be distressing to the person. The aide should suggest social contacts, if possible, when these do not cause distress.

In giving care to a person, the trainee should observe the person as a whole entity--physically, mentally and emotionally. Often an ill person will show a mood change because illness and pain are debilitating, much of his energy is spent in dealing with it and he may become irritable and impatient. Worry about his illness and its effects on the family and financial problems may add to his mental and emotional reactions. The trainee must show patience and understanding of the additional pressures placed on an ill person. Report to the supervisor any prolonged mood change.

Symptoms are things the person will feel and that another person cannot observe. The trainee will have to ask the person, to obtain this additional information about how the person feels. Some of the questions that may be asked are listed below:

- How do you feel?
- Do you have pain?
- If so, show me where the pain is located.
- How severe is the pain?
- Describe the pain (stabbing, burning, does it come and go?).
- Have you had the pain before?
- How long ago did you have the pain?
- When did the symptom start?
- Does anything make the symptom worse (food, noise, bright lights)?
- Are you nauseated?
- Do you have heartburn?
- Has your eyesight changed (dimmer, cannot focus as well, see a halo around lights, cannot see well at night, have double vision, see spots)?
- Do you feel lightheaded?
- Is your skin sensitive to touch?
- Is your throat sore?
- Has your hearing changed (cannot hear as well, noises bother)?

Carefully record on the care plan the observations made while the person is given personal care. These observations can be very important clues to the diagnosis of a disease or to help the health care team in determining the progress of a disease.

For the skill of taking temperature, pulse and respiration, trainees should be individually checked on accuracy of their performance of procedures. Explain and demonstrate the steps to the class. Then have each trainee follow the steps as you again explain and demonstrate the procedures. The following information is from the American Red Cross, Vital Signs Module I: Temperature, Pulse and Respiration, and Communicable Disease Center, National Nosocomial Infections Study Report, Annual Summary, 1976.

TAKING BODY TEMPERATURE is an important method for observing the body response to illness, infection and treatment.

Some authorities feel that certain activities can change the body temperature for a short period of time. Such activities are eating hot or cold foods, drinking hot or cold liquids, having an enema, smoking, taking a very hot or cold bath and exercising. To be sure of accuracy, wait ten minutes to take the temperature if any of these activities have taken place. The temperature will be higher in the evening and lower early in the morning.

There are several ways to take a temperature:

- oral (by mouth)
- rectal (in the rectum)
- axillary (in the armpit)

(Use a large-scale model of a clinical thermometer to help explain the parts of the thermometer.)

There are three kinds of thermometers: oral, rectal and stubby. The long, thin bulbed thermometer is used only for oral temperatures since tissue damage may result if used in the rectum or axilla. The rectal and stubby thermometers may be used to take oral, rectal or axillary temperatures. However, once they are used to take a rectal temperature, they should not be used to take temperature orally because of possible contamination. The rectal thermometer is similar in shape to the stubby thermometer.

Hold the large model of the thermometer to show the parts of the thermometer.

The parts of the thermometer are:

- the bulb end, where the mercury is stored
- the bubble in the glass near the bulb end, which prevents the mercury from dropping into the bulb until it is forced down by shaking the thermometer
- the scale and ridges, which consist of long and short lines, i.e.:

. the long lines, except the arrow, represent one degree

. the short lines represent two-tenths of a degree on Fahrenheit (F) thermometers and one-tenth of a degree on Centigrade (C) thermometers (also called Celsius). The arrow represents the normal temperature at 98.6° Fahrenheit and 37° Centigrade.

Ask a trainee to volunteer as "patient." Demonstrate how to clean a thermometer. The equipment needed is as follows: an oral thermometer, cotton balls or tissues, soap and water--a small tray, optional.

The procedure for cleaning a thermometer is as follows:

- wash hands
- gather equipment
- wet a cotton ball with soap and cool water
- hold the thermometer over a waste container or sink and by the top end opposite the bulb
- begin at the top and wipe down firmly with a twisting motion causing friction
- rotate the thermometer with the fingers while holding the thermometer and rub soap firmly into the grooves and down over the bulb
- discard the cotton ball
- rinse the thermometer with a clean, wet cotton ball using the same downward motion
- wash and rinse the thermometer again
- dry it with a clean cotton ball, wiping from the top downward

The method to shake down a thermometer follows:

- shake the thermometer down to at least 96° F. or 35° C. to insure correct registration of temperature
- stand away from objects to avoid hitting the thermometer and breaking it. Unless one is sure of the procedure, shake it down over a bed or couch in case the thermometer is dropped.
- hold the thermometer firmly at the top end, with the thumb and two fingers
- shake the thermometer with a motion that snaps the wrist, but keep the wrist loose, as though shaking water off the hand

To take oral temperature:

- explain the procedure and have the person sit or lie down
- gather equipment and wet the bulb with cool water so it will not stick to the person's tongue or lips

- place the thermometer under the tongue, near the back of the mouth and a little to one side
- tell the person to keep his lips closed, to breathe through his nose and not to bite down or talk
- leave the thermometer in the person's mouth at least seven minutes to get a more accurate reading
- remove the thermometer and wipe it with a tissue, using a twisting motion from the top toward the bulb end
- read the thermometer in good light:
  - . hold the top end in the right hand with the scale on top, facing the ceiling
  - . locate the mercury by slowly turning the thermometer
  - . note where the end of the mercury is located between the bulb and the top end
  - . if the mercury cannot be located, place the thermometer on a flat surface in good light and move back and forth over it until the mercury can be seen
  - . locate the printed number nearest to the left of the mercury column
  - . the long lines represent degrees and short lines represent two-tenths of a degree. Count the lines between the degree and the end of the mercury column on the right. The right end of the mercury represents the person's temperature reading. (Example, 98.2° F.)

- record the temperature on the daily record, including:

date, time, temperature reading and the method used (oral=O, rectal=R, axillary=A, expressed by the first letter of the word). If possible, find out what the person's temperature is when he is well. It is important to note that the range for a normal temperature is from 97.6° to 99.6° F. Some people have a normal low and others have a normal high temperature. It is very important that the temperature be taken accurately as this is an indicator of the state of health and shows the progress or lack of progress toward getting well.

> NOTE: It is important to soak the thermometer in a disinfectant when more than one person uses the thermometer and after each illness. If 90% ethyl or isopropyl or 3% phenolic germicidal detergent is available, soak the thermometer in it for 30 minutes after it is washed.

- rinse and dry the thermometer
- store the thermometer in its case and away from heat
- wash hands

Pass out a thermometer to each trainee. To get a reading, the thermometer can be placed in warm water or a trainee may take his own temperature. Have each trainee read the thermometer and record the reading on a piece of paper. Check each trainee's reading against the thermometer he read. If there is a discrepancy of no more than two-tenths of a degree Fahrenheit in the trainee's reading, this should be considered passing.

After trainees have learned to read the thermometer, have each trainee clean his thermometer as the steps are explained again; or ask one trainee to explain the first step, then continue around the room with the next trainee explaining the next step, and so on, until all steps of the procedure have been explained.

Rectal temperatures are taken for:

- babies and young children
- all unconscious people
- persons who have difficulty breathing through their nose
- persons without teeth or poorly fitting dentures
- persons with convulsive disorders
- persons who are not responsible for their actions

To take a rectal temperature:

- use a stubby or rectal thermometer. Never use a long-tipped thermometer to take rectal temperatures because of possible tissue damage.
- lubricate the bulb end of the thermometer with a water-soluble lubricant
- explain what is to be done
- have the person lie down on his side with his back toward the homemaker-home health aide and legs bent
- place an infant on his stomach or back on a flat surface or position him face down on the lap
- separate the buttocks and gently insert the tip of the thermometer about one inch into the rectum. Hold the thermometer in place two to four minutes. Rest the hand against the person's buttocks as the thermometer is being held in place. If there is motion, the hand will move with the person and lessen the possibility of tissue damage in the rectum.
- remove the thermometer after two to four minutes, pulling it out in a straight line
- wipe the thermometer with a tissue, using a twisting, downward motion to the bulb end
- the normal range for rectal temperature is approximately one degree above oral temperature: 98.6° F.-100.6° F. or 37° C.-38° C.

Axillary temperature recordings are not considered as accurate as oral or rectal temperatures and are done when other methods cannot be used. Follow these steps for taking the axillary temperature:

- have the person assume a sitting or lying position
- pat (not rub) the axilla dry with a tissue
- place the dry bulb of the stubby or rectal thermometer in the armpit, and have the person hold his arm tightly against his body
- ask the person to grasp his opposite shoulder with his hand to help hold the thermometer in place NOTE: Make sure the bulb end does not sharply press into the skin.

The next topic is how to take the pulse and respiration. Both of these procedures can be done while the temperature is taken.

TAKING THE PULSE is a method of counting the number of heartbeats per minute. This is called the pulse rate. The normal pulse rate at rest for most adults ranges from 70-90 beats per minute. The pulse rate for the female may be slightly faster than in a male. The normal pulse rate at rest for a newborn may be as high as 130 beats per minute. For a small child of three, the pulse rate will be around 100. A child of twelve will have a pulse rate of approximately 80. Unless the effect of exercise is being measured, the pulse rate should be taken after the person has rested quietly for ten minutes or more.

To take the pulse:

- check a baby's heartbeat by placing the flat part of the fingertips on the chest, slightly below the nipple to the left of the breastbone. Have a clock or watch with a second hand where it can be seen easily. Count the pulse for a full minute.
- for an older person, place the arm across the chest. Explain that the pulse is being counted.
- find the pulse by placing the flat part of the fingertips on the inside of the person's wrist, just below his thumb. Never use the thumb to count the pulse, as the thumb's pulse may be felt instead of the person's pulse
- press gently between the tendons and the wrist bone
- count the pulse for 30 seconds for adults and multiply this number by two to get the pulse rate for one minute. If there is any question or irregular heartbeat, count the pulse for 60 seconds.
- record the number of pulse beats per minute
- contact the supervisor if the pulse is irregular, extremely rapid, weak or extremely slow

To take the respiration:

- count the number of breaths taken within 30 seconds. This should be done while the fingers are still on the person's pulse and the person is unaware of the counting. (Respiration rate can change if the person is aware it is being counted.) A respiration is one inhalation and one exhalation. Multiply by two the number of respirations counted to get the rate per minute and record.
- it is normal for a baby or small child to breathe more rapidly than an adult. The adult respiratory rate will range from 14 to 20 breaths per minute. Lung disease or fever may cause the respirations to be faster.

URINE TEST FOR SUGAR. The homemaker-home health aide may need to perform a test for sugar in the urine for persons who have diabetes. There are several methods for testing for sugar. The directions on the testing materials provided in the person's home should be followed precisely. The most common test involves the use of test tapes or paper. The principle underlying the test is a change in color of the tape or paper when it is dipped in urine. Included with the test will be a chart or color code used to determine the amount of sugar in the urine. The steps in testing are:

- test urine at the time(s) of day indicated in the plan of care
- tear off a piece of tape (the test tape may be in a dispenser similar to a scotch tape dispenser)
- dip the tape in a sample of urine
- wait a minute
- compare the color of the tape with the color chart
- record the result in terms as indicated on the chart
- follow instructions for reporting changes as indicated in the plan

The instructor may use Exercise 1 to practice taking pulse and respiration. The instructor may wish to reproduce the daily record sample for use as a handout. If no handouts are utilized, put a sample of a daily record or care plan on the board or flipchart.

Since the person's condition may change daily, the homemaker-home health aide will not want to trust to memory any of the things seen or evaluated about the state of health. After a change in the person's condition is observed, and following the completion of a procedure, it should be promptly recorded. If specific instructions are given by the supervisor, the aide should repeat the instructions to be sure everything is clearly understood. Record special instructions given by the supervisor on the back of the daily record and include the date, time and the supervisor's name.

The daily progress of the person cared for can easily be followed if observations are recorded carefully and information recorded on one form. This can greatly assist the health team in evaluating the health status of the person.

One example of a form used to record treatments, eating patterns, signs and symptoms and other observations is shown below.

Doctor________________________ Name of Person____________________

Name of Homemaker-Home Health Aide______________________________

Date and Hour	Temperature Pulse and Respiration	Diet Eating Pattern	Treatments	Elimination	Remarks Signs and Symptoms
. . .	. . .	. . .	. . .	. . .	. . .

SELECTED REFERENCES

American Red Cross. Family Health and Home Nursing Text Book. Garden City New York: Doubleday. 1979.

American Red Cross. Home Nursing Instructor Guide. Washington, DC: American Red Cross. Publication date pending.

American Red Cross. Vital Signs Module I: Temperature, Pulse and Respiration. Washington, DC: American Red Cross, 1976.

Campbell, Claire, R.N., M.S. Nursing Diagnosis and Intervention in Nursing Practice. New York: A Wiley Medical Publication. 1978.

DuGas, Beverly Witter. Introduction to Patient Care. 3rd ed. Philadelphia: W.B. Saunders Co. 1977.

Henderson, Virginia, and Gladys Nite. Principles and Practices of Nursing. 6th ed. New York: Macmillan Publishing Co., Inc. 1978.

Isler, Charlotte, R.N. The Nurses Aide. 2nd ed. New York: Springer Publishing Co., Inc. 1973.

Larkin, Patricia Dubbert, M.A., R.N., and Barbara A. Backer, M.S., M.A., R.N. Problem-Oriented Nursing Assessment. New York: McGraw-Hill. 1977.

Malasanas, Lois, Violet Barkanskas, Muriel Moss and Kathryn Allen. Health Assessment. St. Louis: The Mosby Company. 1977.

Wood, Lucille A. and Beverly J. Rambo. Nursing Skills for Allied Health Services, Vol. 1. Philadelphia: W. B. Saunders Company. 1977.

Unit B: Assessment

Answer the following by putting the letter of the right column on the blanks provided on the left column.

1. _____Include the changes in color of the skin, pain, how a person feels, fever, vomiting.

2. _____Critical, irritable, demanding angry, aggressive.

3. _____Spots or white patches, hoarseness, difficulty in swallowing are signs and symptons when this part of the boddy is diseased.

4. _____The length of time to wait after drinking hot or cold liquids before taking the temperature.

5. _____Normal body temperature.

6. _____A procedure to avoid breaking the thermometer.

7. _____A method of taking temperature when other, more efficient methods cannot be used.

8. _____The normal range is approximately 1 degree above the oral temperature.

9. _____The normal rate for a child is 130 beats per minute.

10. _____It is equivalent to one inhalation and one exhalation.

11. _____May be used by the homemaker-home health aide to write observations about the person.

12. _____Changes in the blood pressure and pulse are signs and symptoms of this body system.

13. _____A sign that you are healthy.

14. _____The number of minutes the thermometer is left in place when taking oral temperature.

15. _____Important things to note when taking the pulse.

A. Throat

B. 3 minutes

C. Ability to work efficiently and with enthusiasm

D. 98.6° F. or 37° C.

E. 7 minutes

F. Rectal temperature

G. Rate, thythm and volume

H. 10 minutes

I. A care plan or daily record

J. Pulse

K. Attitude change

L. Circulatory

M. Axillary method

N. Stand away from furniture when shaking it

O. Signs and symptoms

P. Respiration

ANSWERS:

1. O
2. K
3. A
4. H
5. D
6. N
7. M
8. F
9. J
10. P
11. I
12. L
13. C
14. E
15. G

AIDS

Exercise 1: Practice in Taking Pulse and Respiration

Exhibit 1: Taking an Oral Temperature

Discussion Questions 1: Assessing Body Functions

Worksheet 1: Physical Illness Symptoms

Handout 1: Signs and Symptoms

Handout 2: Sample Daily Record

Handout 3: Sample Personal Care Plan

Exercise 1: Practice in Taking Pulse and Respiration

The trainees will practice skills in taking pulse and respiration.

- Review the procedure for taking pulse and respirationn.

- Have trainees pair off and take each other's pulse and respiration.

- The instructor should spot check the practice. A discrepancy of no more than five counts in pulse rate and two counts in respiration should be acceptable.

- Discuss the average ranges and special situations such as infants' pulse rate.

Exhibit I: Taking an Oral Temperature

CLEAN
SHAKE
WET
EXPLAIN
PLACE
TELL
LEAVE
REMOVE
READ
RECORD

Discussion Questions 1: Assessing Body Functions

1. Why is it important for the aide to be able to assess the person for signs and symptoms of illness?

2. What is the difference between normal, average temperatures for oral, rectal and axillary temperatures?

3. What is the average range of respirations for an adult?

4. How does the pulse rate differ for a child and an adult?

5. How should unusual signs or symptoms be reported?

PHYSICAL ILLNESS SYMPTOMS

WORKSHEET 1

SYMPTOMS	WHAT TO NOTE	WHAT TO REPORT
1. Overall appearance		
2. Face		
3. Nose		
4. Throat		
5. Mouth		
6. Voice		
7. Skin		
8. Weight		
9. Appetite		
10. Sleep		
11. Fever		
12. Pulse		
13. Respiration		
14. Pain		
15. Vomiting		
16. Elimination		
17. General Condition		

Handout 1: Signs and Symptoms

Signs as they might appear in the body systems:

THE SKELETAL SYSTEM

- swelling of ligaments, joints, limbs
- pain in bones or joints evidenced by slow movements and grimace
- hot areas
- loss of strength

THE SKIN

- Color of the skin
  - red
  - pale
  - bruised
  - yellow
  - green
  - white
- Texture
  - scaly patches
  - rough
  - hives
  - rashes
- Moisture
  - clammy
  - dry
  - oily
- Temperature
  - cool
  - hot
- Swelling
  - wounds
  - moles
  - lumps/spots
  - sores
  - warts
- Hair
  - dry
  - dull
  - oily
  - loss
  - scalp scaling
  - dandruff

MUSCULAR SYSTEM

- bruising
- swelling
- slow movements
- loss of strength

RESPIRATORY SYSTEM

- slow breathing
- noisy breathing
- cough
- sputum: note odor, color and thickness
- shallow breathing
- grimace when breathing
- rapid breathing
- difficult breathing
- nose: stopped up
  - bleeding
  - dryness

CIRCULATORY SYSTEM

- swelling of limbs, ankles, feet
- changes in pulse rate: fast, slow, irregular, weak
- color of hands, feet, lips, and nails: pale, bluish
- lymph nodes swollen or knots at neck, groin, under arms

TEMPERATURE

- normal
- high
- low

MOOD CHANGES

- irritable
- withdrawn
- demanding
- anxious
- aggressive
- abusive
- sullen
- depressed

ENVIRONMENTAL

- disturbed by noises
- limited heat available for elderly
- insufficient bedding
- no visitors or too many

Handout 1: Signs and Symptoms (continued)

DIGESTIVE SYSTEM

- Throat and Mouth
  - cracks at corners of mouth
  - redness
  - swelling
  - spotted or patches
  - difficulty in swallowing
  - hoarseness
  - diseased gums--bleeding
  - bad breath
  - coated tongue

- Stomach
  - bloating
  - lack of appetite
  - vomiting
  - nausea
  - drinking large amounts of water

- Intestines
  - bloated
  - fullness
  - grimace
  - reaching for abdomen

- Feces
  - consistency: hard, soft, loose
  - color: black, clay, blood-tinged, brown, yellow, etc.
  - frequency and amount
  - pain when moving bowels

REPRODUCTIVE SYSTEM

- Menstrual Periods
  - excessive bleeding
  - irregular period
  - odor

- Vaginal Discharge

- Discharge from Penis
  - testicles: lump, swelling

- Breasts
  - lumps
  - soreness
  - nipple discharge

NERVOUS SYSTEM
- twitching
- numbness
- shaking
- pain (may hold the area hurting or grimace with movement)
- slow to react
- cannot awaken

EYES
- bright
- dull
- discharge
- red
- sensitive to light (squint)
- moist, glassy
- whites: yellow color

EARS
- discharge
- pulling at ear (child, especially, may mean earache)
- loss of balance

URINARY SYSTEM
- urine:
  - color: yellow, rust, red, sediment
  - frequency and amount
  - pain over bladder region
  - dribbling
  - unable to empty bladder completely
  - feeling of urgency

UNIT C: PREVENTING THE SPREAD OF DISEASE

ESTIMATED TIME ½ hour

INSTRUCTOR Professional nurse

INTRODUCTION

This unit describes the skills that can be used to prevent the spread of disease. Included in this unit are demonstrations of skills and general concepts of cleanliness, handwashing technique, and how to dispose of personal waste products.

EXPECTED OUTCOMES

The trainee will be able to:

- demonstrate the safe disposal of body wastes
- demonstrate the skill of handwashing
- show the person how to cover the nose and mouth when sneezing or coughing

SUGGESTED MATERIALS/EQUIPMENT

- newspaper
- paper bag
- spring clothespin
- paper towel or tissue
- basin, pitcher
- soap
- soap dish
- handwashing equipment for groups of three

CONTENT

(This unit deals with the fundamentals of personal care and how they relate to preventing the spread of disease. Demonstrations will include handwashing and improvising a paper bag, with the trainees returning demonstrations. The disposal of wastes will also be discussed.)

The fundamentals of personal care promote safe, effective, efficient ways to provide care, promote good health, and prevent illness. They apply to the homemaker-home health aide as well as the person receiving care.

(Write the fundamentals on the board or chart: Safety, Comfort, Economy, Neatness, Effectiveness.)

They are:

Safety: Safety should be a part of any procedure that is done. Safety is especially important in assessing the home environment, applying procedures, and in moving the ill person.

Comfort: Comfort should be considered in every procedure. For example the person and the homemaker-home health aide should be comfortable while care is being given, the individual afforded privacy to increase his comfort, and the person positioned comfortably after care is given to enhance his comfort.

Economy: Economy applies to saving time, effort and supplies. Materials and equipment can often be improvised to decrease the cost of health care.

Neatness: Appearance of the person, the environment, and the homemaker-home health aide are important to promote a pleasant environment. Also, orderliness of the room and equipment helps save steps and time.

Effectiveness: All procedures should be evaluated. When a procedure has produced the desired effect, then it can be considered successful. The success of any procedure is also measured by the effectiveness in promoting the person's health. The person should express a feeling of well-being and comfort

All of the fundamentals apply to any skill performed. In giving personal care, one of the first skills to learn is how to dispose of body wastes. Body wastes from the sick room may carry infection and must be disposed of carefully to reduce the spread of infection. Wastes may include used paper tissues, sputum, dirty dressings, uneaten food, body excreta, and vomitus.

In disposing of solid wastes use pickup tongs or a spring clothespin to pick up the material. If these utensils are not available, carefully grasp with the fingers only the cleanest part of the material or pick it up with a paper towel. The soiled material should be put into a paper or plastic bag and disposed. In using a paper or plastic bag for disposal, turn down a cuff on the bag. With a paper bag the cuff will help keep it open making disposal easier. The cuff also protects the hands when closing the bag as the fingers are slipped under the cuff which is the clean area. When a paper bag is not available it is possible to improvise one from a newspaper. Making a bag can also be taught to the sick person as a diversional activity.

(If no paper bags are available in the home, it is possible to improvise one from newspaper sheets. Demonstrate the method for making a paper bag and explain the steps while you are doing it.)

Procedure for the newspaper "paper bag":

- start with 2 full-sized sheets of newspaper for a large bag or 2 single sheets for a small bag

- place on a table two thicknesses of newspaper

- fold the newspaper in half bringing the bottom of the paper to the top so that the fold is at the bottom and parallel with the edge of the table

- bring down the upper edge of the top thickness of paper to the fold at the bottom which makes a cuff to give support to the bag

- turn the paper over, unfolded side up, keeping the bottom fold toward the edge of the table

- fold the paper in thirds starting at either side and crease well

- lock in one of the folded thirds by tucking one side under the fold of the other

- bring down the flap at the top folding it over the locked thirds

- place the hand in the opening at the top of the bag, standing the bag on end - the flap helps to keep the bag upright, can be fastened to the bed with a safety pin, tucked under the mattress, or used to cover the bag when filled with soiled material

Pass out two sheets of newspaper to each class member. Explain the steps again as each trainee makes a bag.

The next discussion does not involve a demonstration.

Liquid wastes should be disposed of by pouring them into a container that has a lid and can be disposed of down the sink drain or into the toilet. The container holding the liquid should be washed with soap and water. When disposing of contaminated wastes, it is preferable to raise the toilet seat and pour the liquid into the bowl.

Handwashing is the next skill to be demonstrated. Assemble the needed equipment and demonstrate to the class how to wash the hands. List equipment on the board: soap, pitcher of water, basin, soap dish, clean towel. Refer to Exhibit 1.

The hands are a principal source for carrying germs and transmitting infections and disease. When providing personal care, hand washing is important to protect both the person receiving care and the person giving care. It also protects other members of the family and community if an infectuous condition is present.

Procedure for washing of hands:

Hands should be washed when soiled but especially:

- before preparing food
- before and after giving personal care
- after using the toilet
- after touching the nose or mouth

The method for washing the hands is as follows:

- assemble the equipment
- roll up long sleeves; remove wrist watch and costume jewelry or jewelry that could easily scratch or injure the person
- wet and soap hands thoroughly
- run water over the bar of soap to clean it
- rub the soap to make a lather
- wash the entire surface of the hands, especially between the fingers, around and under the fingernails, and well above the wrist
- scrub under the nails with a nail brush if available
- run water over the soap again to clean it
- rinse with the hands lowered to allow soapy water, dirt and oil to drain off the hands
- soap the hands again and repeat the hand washing process to remove the loosened dirt and oil
- place the bar in a soap dish in which it will drain well
- rinse hands
- elevate hands, draining water from the fingers down to the wrists, allowing water to run from the cleanest to the less clean area
- turn off the tap by using a towel, which keeps the hands from getting soiled again if touching the tap
- dry carefully, using a paper or clean cloth towel, or by shaking hands in the air
- use hand cream as needed to avoid chapping

If hand washing facilities are not available, have trainees divide into groups of three. Ask one trainee to wash his hands while one pours water and the other explains the steps. Rotate procedure among the group members so everyone washes his hands. Carefully check each trainee's procedure.

The next method of preventing the spread of disease is covering the nose and mouth while coughing or sneezing.

The mouth and nose should always be covered with a tissue or handkerchief when coughing or sneezing to help prevent the droplets spreading into the air for others to breathe in. Since upper respiratory diseases can also be spread by the hands, hands should be washed after sneezing or coughing and after touching the nose or mouth. Tissues should be disposed of in a container or bag that closes,as discussed previously.

SELECTED REFERENCES

UNIT C: Preventing The Spread of Disease

American Red Cross. Family Health and Home Nursing Textbook. Garden City, New York: Doubleday. 1979.

DuGas, Beverly Witter. Introduction to Patient Care. 3rd ed. Philadelphia: W.B. Saunders Co., 1977.

The Canadian Red Cross Society. Care in The Home. Toronto, Canada: The Canadian Red Cross Society, 1971.

Thompson, Ella M., R.N., B.S., and Caroline Bunker Rosdahl, R.N., M.A. Textbook of Basic Nursing. Philadelphia: J.B. Lippincott Co., 1973.

Wood, Lucile A., R.N., M.S. and Beverly J. Rambo, R.N., M.A., M.N. (eds) Nursing Skills for Allied Health Services. Vol. 1. Philadelphia: W.B. Saunders Co., 1977.

UNIT C ASSESSMENT:

Please fill in the blanks of the following questions:

1. A fundamental principle of personal care that involves saving time, effort and money is ____________________________________

2. When pickup tongs or clothespins are not available to pick up dirty waste materials, the health aide can use her fingers by grasping the ______________________ part of the material.

3. A ______________________________ can be used to improvise when a container is needed for soiled solid materials.

4. Liquid wastes can be disposed of by _________________________.

5. Watches or costume jewelry should be removed when caring for an individual because they could easily ________________the person.

6. The mouth and nose should always be covered with a tissue or handkerchief when _________________________ to prevent infecting others.

7. The success of any nursing procedure is measured by its __________ in promoting health.

8. The nursing fundamental of ______________________ is involved when the wrinkles in the person's bed are removed.

9. Homemaker-home health aides should always _______________ before and after caring for a person.

10. Wastes may include _______________________________________.

ANSWERS:

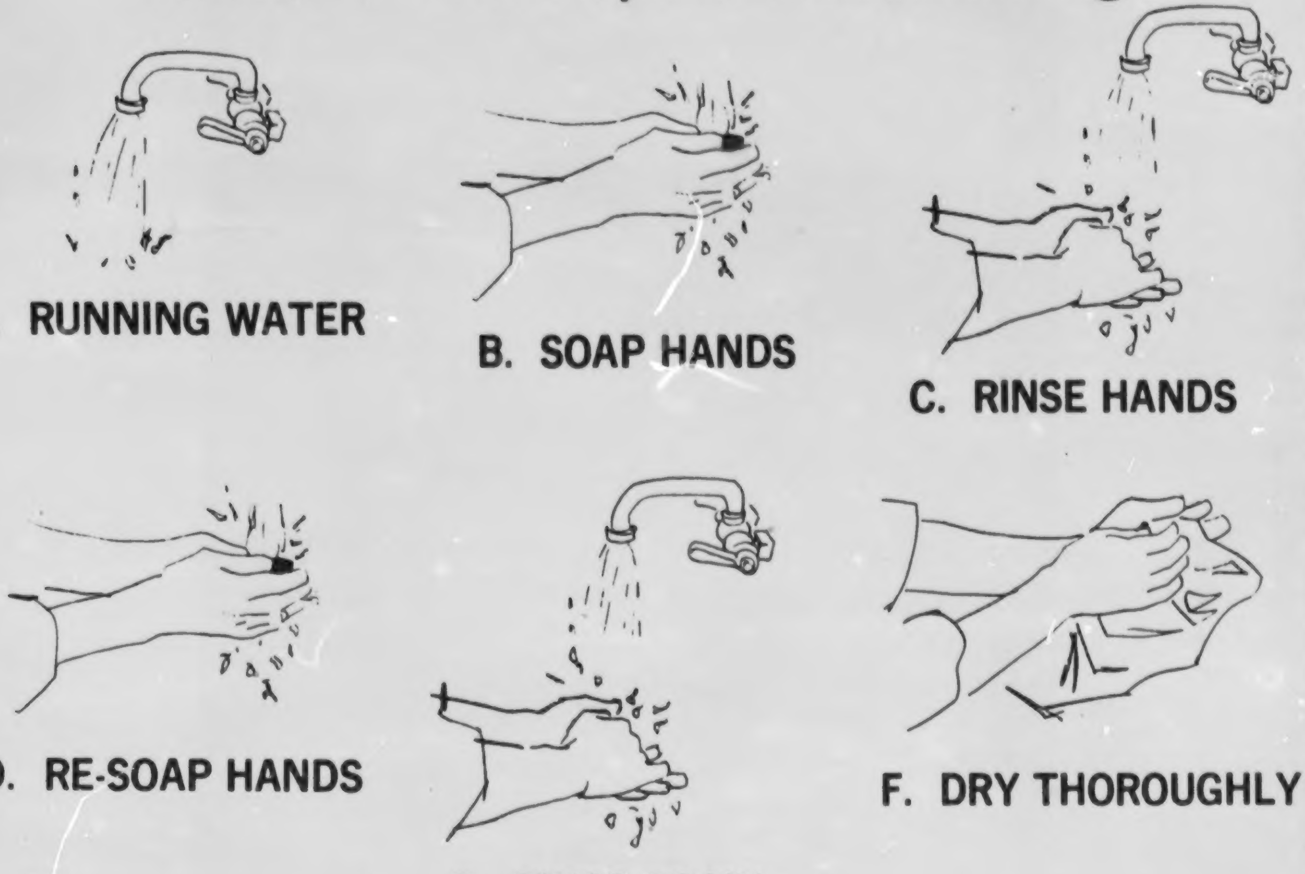
1. economy
2. cleanest
3. newspaper
4. flushing down the toilet
5. scratch or hurt
6. coughing or sneezing
7. effectiveness
8. neatness or comfort
9. wash hands
10. used paper tissues or sputum or dirty dressings, etc.

AIDS

Exhibit 1: The Steps in Handwashing

Discussion Questions 1: Preventing the Spread of Disease

Exhibit 1: The Steps in Handwashing



A. RUNNING WATER

B. SOAP HANDS

C. RINSE HANDS

D. RE-SOAP HANDS

E. RINSE AGAIN

F. DRY THOROUGHLY

Discussion Questions 1: Preventing the Spread of Disease

1. Why are the hands washed twice?
2. How are dry and liquid wastes safely disposed?
3. Explain what fundamentals of care are used in washing the hands.
4. Why is jewelry removed before washing hands?
5. When should hands be washed?
6. Why should the nose and mouth be covered when sneezing or coughing?

UNIT D: CARE OF THE PERSON IN BED

ESTIMATED TIME 6 hours

INSTRUCTOR Professional nurse

INTRODUCTION

The fundamentals of personal care are stressed in this unit. The importance of the concepts of safety and the use of good body mechanics for both the person receiving care and the aide are discussed. This includes assuring proper body alignment and body support. Meeting the health needs of the person receiving care include: hygiene and grooming, elimination, skin care, foot and mouth care and changing an occupied bed.

EXPECTED OUTCOMES

The trainee will be able to:

- give personal care meeting the needs for elimination, hygiene, grooming, skin care, foot and mouth care
- position the person in bed using principles of good body mechanics
- make an occupied bed
- identify environmental dangers to the person in bed

SUGGESTED MATERIALS/EQUIPMENT

bed (made up)

bed linen: 1 flat sheet (contour sheet optional), 1 pillow case, 1 draw sheet or folded flat sheet (waterproof protector optional)

5 pillows

2 bath towels

2 wash cloths

wash basin, soap and soap dish

bedpan and urinal

mouth care: dental floss, soft bristled toothbrush, glass of water, emesis basin, drinking straw, mouth wash, toothpaste

cup for dentures; dentifrice

gauze

moisturizer for lips/lipstick, if preferred

foot and skin care: lotion, powder, nail file, nail clippers

CONTENT

This unit gives instructions about the skill of giving personal care. It is important to demonstrate the skills, explain the steps and have the trainees participate in a return demonstration so that each procedure can be evaluated to see if the trainee is doing it correctly.

A person may be confined to bed for a variety of reasons. A person may have had surgery, may be convalescing after a stroke, may have a long-term illness such as cancer or multiple sclerosis, may have a short-term illness such as the "flu" (influenza) or may be in the last stages of an illness before death.

It is very important to meet the human needs of the person receiving care. These were discussed in Section II, Working with People. They are: love and affection, recognition, acceptance, security, trust, socialization, food, clothing, shelter, rest, activity, avoidance of pain and escape from danger. *(Exercise 2 may be used in this discussion.)*

In giving personal care, the plan of care should include the fundamentals of care stated previously: safety, comfort, economy, neatness and effectiveness. The aide will help the health team in the ongoing assessment by observing the person, physically and emotionally. It is important to know how the individual feels about receiving personal care involving care in bed. Feelings about personal care may involve embarrassment or reluctance to have certain procedures performed because of their intimate nature, or simply not wanting to be touched. Persons have a right to refuse service. If this occurs the aide does not insist, even though the procedure is part of the care plan, but discusses it immediately with the supervisor.

The goals for the person's care plan are developed by members of the health team. A recurrent theme should be how to give care that meets the goals and fundamentals of care but still allows the person to be as independent as possible. Observations made by the homemaker-home health aide, the care goals, the care given and evaluation of the care all should be recorded on the care plan and serve as a guide to the health team for planning future care. The primary goal of self-care should be emphasized, as well as that of teaching members of the family to give the needed care.

In giving personal care to the person in bed, observations also should be made of the environment. SMOKING SHOULD NOT BE ALLOWED IN BED unless someone stays with the person. Essential items, such as good lighting and a system to signal the aide or a family member (which may be no more than a bell or glass and spoon), should be within easy reach. Electric cords should be located so they are out of the way. They should also be checked for frays or loose connections. Gas room heaters should be ventilated. All heaters should be provided with a front guard to keep objects away from the coils or flames. Good ventilation and circulation of air will add to the person's comfort but drafts should be avoided.

An infant's bed should be free of pillows and loose blankets. Check toys and clothes for small parts that could be swallowed. A child should not have access to plastic material with which he could cover his head and smother.

A fire escape route should be determined and understood by the person in bed and by all family members. Smoke detectors should be in every home with an invalid. In some communities the fire departments will install labels on the windows of the handicapped.

Body Mechanics:

Discuss and demonstrate the principles of body mechanics when caring for a person who needs help.

Before giving care, the principles of body mechanics should be reviewed and clearly understood. Good posture should be maintained at all times: head erect, buttocks pulled in, stomach muscles tight, chest high and shoulders back.

Use a wide base of support, with feet apart and one foot forward, when standing for a period of time. The principle is that the broader the base of support, the lower the center of gravity and the easier it is to maintain balance.

Keep the back straight and the knees and hips flexed. When reaching down to a low place, use the large muscles of the legs for strength when lifting an object. Never bend from the waist to pick up or move an object.

Point the feet in the direction of the movement for side and forward motion, in most instances. This prevents twisting of the spine and allows movement with the body in good alignment.

Stay close to the person to conserve energy and prevent strain. Work at waist level if possible.

Have each trainee demonstrate good body mechanics when standing, bending and lifting an object. Have each trainee pick up an object from the floor, checking each to see that the procedure is done correctly. Or, have trainees assume correct posture in relation to moving a person in bed or helping a person out of a chair.

Positioning the Ill Person:

The next demonstrations are moving and positioning a person in bed. Ask for a volunteer to act as the person receiving care. Write on the board the equipment needed: 2 small towels, 5 pillows, 2 wash cloths. Have each trainee demonstrate positioning a person in each position.

The comfort and position of the person are important when the person is in bed for a period of time. Comfort is increased by aligning the person's body correctly:

- give support to the curves of the spine with a pillow under the head and neck; the pillow should reach down to the shoulders
- place a small flat pad, such as a rolled towel, under the small of the back
- support body joints, using pillows, folded towels or wash cloths
- legs should be supported to relieve pressure on hip joints, with a small pillow or pad placed under the person's ankles and knees to prevent pressure on heels and legs
- change of position is important at least every hour, night and day, if the person cannot move himself, (1) which helps to:
  - . improve circulation
  - . improve muscle tone
  - . prevent joint deformities
  - . provide some diversion
  - . prevent pressure sores on ears, heels, buttocks, back, elbows, hips and other bony parts
  - . prevent strain and fatigue

A primary concern is the emotional adjustment a person must make,when confined to bed,because of worry, inactivity and dependence. Help the person express his feelings and encourage and praise him whenever possible.

Positioning a person in a semi-sitting position, and on his back.

The semi-sitting position may be attained by raising the head of the bed or raising the person to a sitting position by locking arms. (*See Unit E.*) This position may be maintained by crossing two pillows and placing a third pillow across them, or a back rest may be used.

> "A back rest may be improvised from a cardboard box that has four flaps as a top. Cut down the front side of the box at the corners and let the front side fall forward and lie flat. Score the short sides of the box diagonally from the top to the bottom on the inside of the box. Bend the sides inward along the scored lines. Bring forward the cover flap at the back of the carton. Place it over the folded sides. Bring the front side of the box up and over the cover flap and folded sides. Fold the excess cardboard over the back of the box and tape or tie the sides securely." (2)

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(1) Henderson, Virginia, and Gladys Nite. Principles and Practice of Nursing. 6th ed. New York: Macmillan Company. 1978. P. 732.

(2) American Red Cross. Family Health and Home Nursing. New York: Doubleday & Company, Inc. 1979. P. 512.

Place a small pillow or flat pad under the small of the person's back and a pillow under each arm for support. Add a hand roll made from a wash cloth if the person tends to clench his fist if the hand is paralyzed. Use a pad or pillow at the side of the hips to keep the feet from rolling outward.

Positioning the person on his back is the same except that the back rest and pillows are removed and/or bed lowered. Place a pillow beneath his head, reaching down to his shoulders to keep the shoulders forward.

The next demonstration is positioning a person on his side. Demonstrate turning the person from his back to the side.

When turning the person and positioning him, if there is no help available the person should always be turned toward the aide. Ask for help whenever possible.

Procedure:

- explain what will be done
- move the person to the side of the bed near the homemaker-home health aide
- flex the person's arms and place them across his chest
- place his knees together in a flexed position, supporting joints from beneath as they are positioned
- go to the far side of the bed so the person will be rolled toward the aide
- place one hand on his hip and the other on his shoulder
- on signal, roll him gently but quickly from his back to his side
- adjust the pillow for his head so it reaches down to his shoulders
- position arms where comfortable at sides or raised
- use handrolls as needed

Elimination of Body Wastes:

Demonstrate how to put the bedpan and urinal in place and remove them. Have each trainee return the demonstration.

As discussed in Unit B, Body Function, elimination of body wastes takes place in a number of ways: through perspiration, evaporation from the lungs, bowel movements and urination. The person in bed may be very concerned about how he can eliminate through his kidneys and bowels while in bed. This is particularly true of the elderly. Be aware of his concerns and respond quickly to his needs. In giving the bedpan or urinal to a person, consider his privacy and the importance of making him feel comfortable.

Procedure for use of bedpan:

- warm the bedpan with warm tap water and dry it
- cover the bedpan with a newspaper or washable cloth when carrying it to the person
- add extra protection to the bed, even if a plastic or rubber sheet is used on the mattress; an extra cloth or newspaper pad may be placed under the person's hips
- sprinkle talcum powder or cornstarch on the bedpan seat--only if there are no open sores or dressings--to make it easier to get on and off the pan; if the person is thin, add a small pad to cushion the seat (a sanitary pad or soft cloth may be used)
- place the bedpan on the bed near the person's hips, open end toward the foot of the bed
- fold the top covers to one side to avoid soiling and partially drape the sheet or blanket to prevent chilling and provide privacy
- if the person needs help in raising the hips, have him flex his knees, place one hand under the small of the back and, on signal, push his hips up as he pushes down with his hands and heels, and with the other hand place the bedpan under his hips and adjust the pan for comfort
- assist the person to a sitting position if possible and provide toilet paper and a call signal; then leave the room to allow for privacy if it is safe. Remind the female to wipe from front to back to avoid bringing germs into the vagina and bladder.
- have the person flex his knees and push down with his heels and hands as the bedpan is removed
- remove the bed protector, cover the pan, and take it to the bathroom
- help the person to wash his hands
- position him comfortably
- inspect the contents of the bedpan
- rinse the bedpan with cold water to prevent coagulation of proteins
- clean the bedpan with soap and water, cover and store
- record the contents and time of elimination on the care plan

Procedure for use of urinal:

- use protector under the person's hips
- give the person the urinal, or if he is helpless, place it between his legs in a position to collect the urine
- provide for privacy by replacing covers, leaving the room and putting the call system nearby
- record results; measure urine if ordered
- rinse the urinal with cold water
- wash urinal, cover and store

To Re-establish Bowel and Bladder Routine:

The following steps may help to re-establish bowel and bladder routine, if needed. Good bowel and bladder function may also be maintained by the same procedures. The doctor may order a suppository, laxative or enema to help stimulate the bowel.

Procedure:

- establish the normal pattern for elimination by maintaining a record for several days
- give urinal and bedpan at regular intervals based on observations and when a desire is expressed
- encourage plenty of fluids during the day, but less in the evening; strong urine resulting from too few fluids is irritating and can cause incontinence
- encourage the person to eat more fiber foods (*See Section III, Unit B.*)
- instruct the person in other signs of a full bladder--sweating, chills, headache, restlessness

Bathing and Grooming:

This section presents the concepts of hygiene and grooming. Demonstrations and return demonstrations should be done for the bedbath, foot care, mouth care and the back rub. The bedbath should be supervised in the field practice.

The purposes for giving a bath in bed are:

- to cleanse and refresh the person
- to aid in the elimination of wastes from the skin
- to aid in stimulating circulation
- to provide passive and active exercise

How often a bath is given depends on such factors as the physical condition of the person, age and type of skin. Older people have less oil and perspiration; therefore, a daily bath with soap may not be desirable. Washing the rectal and genital areas and under the arms may be all that is needed. Some black people are also inclined to have dry skin. However, a cool sponge bath will be needed if the person perspires profusely.

Some few points to follow in bathing a person are:

- choose a bath time convenient for the family and the person, if possible

- make sure the room is warm and equipment organized

- keep the person warm with a sheet or blanket while bathing

- place a towel under the part being washed to keep the bed dry

- change water when soiled, soapy or cool

- test water temperature on the inner wrist to make sure it is not too hot, especially for the older person or baby

- the homemaker-home health aide should provide as much privacy as possible for the person

- assess the condition of the person as he is bathed, especially noting changes in the skin of older people and whether or not there are reddened areas or breaks in the skin where bed sores may develop

- if a bath is given semi-weekly or weekly, the pressure areas of the skin will need to be examined daily

- use soap sparingly

- encourage the person to give himself as much of his bath as possible. In so doing, he gets some exercise and develops security in doing for himself.

To give the bath:

- explain what will be done and the reasons for the various techniques

- place a cover over the top cover to be used as a bath blanket. A bath blanket can be made by sewing several large towels together. Slide the top covers from under the bath blanket. Help remove the bed clothes as needed.

- Place a towel under the person's head

- wrap the washcloth around the fingers and palm, anchoring it with the thumb; fold over the part extending beyond the fingers and tuck under at the bottom edge of the cloth at the palm to make a bath mitt (this eliminates dangling ends which may be uncomfortable to the individual)

- wash eyes with clear water, cleansing from the outer corner of the eye to the inner part of the eye (as the normal flow of tears is from the outer to the inner part of the eyes), using opposite corners of the cloth for each eye

- wash the face from midline outward using a firm but gentle motion, using clear water for the face unless the skin is oily (some people prefer creams for cleansing); wipe from outer to inner part around eyes

- wash, rinse ears and dry

- place towel under the arm and another towel near the hand to set the basin on

- lower the person's hand into the basin; allow it to soak as the arm is being washed

- wash and rinse the other arm and soak hand, drying carefully, especially between the fingers. Push cuticle back and clean under the nails. File nails as needed.

- put towel over the chest and abdomen: bring bath cover down to thighs.

- wash, rinse and dry neck, chest, and abdomen. Cover chest and abdomen. If the person has an ostomy (a surgical opening into colon),the homemaker-home health aide will need to give careful attention to care of the skin around it. (The supervisor should supervise the homemaker-home health aide the first time skin care is given around the ostomy.)

- remove bath cover to expose the leg and place towel under the leg

- place a towel under the basin placed near the foot

- lower foot into basin to soak; this will help soften the nails and skin and feels good

- wash, rinse and dry leg

- repeat above steps with other leg

- dry carefully between the toes

- observe feet and use pumice stone or emery board to smooth callouses. Clean under the nails.

- turn the person on his side; drape around the back and buttocks

- tuck the towel along under his buttocks and shoulders

- wash, rinse and dry his back and buttocks; cover his back

- place a towel under his buttocks. Teach the person to wash carefully between the buttocks and the genitalia. Rinse and dry thoroughly. Remind the female to wash from the front to the back to avoid bringing germs from the rectal area to the vagina and bladder. If the person is unable to wash his buttocks and genitals, the aide should complete this part of the bath for him.

- also, if the person has a urinary catheter in place, he should be taught to wash carefully around the catheter with soap and water and dry the area well

- apply body lotion or powder, as desired

Have a volunteer or life-size mannequin in bed so that trainees can each practice making the mitt, and wash a part of the body. Observe the procedure for each trainee.

To Help Prevent Development of Pressure Sores:

The following measures should be carried out for avoiding the onset of pressure sores:

- help the person with exercise or activity that is allowed in the care plan
- turn the person frequently, since he is not able to move himself to avoid pressure to one area for a prolonged time
- make sure the bottom sheet is pulled taut, checking for any possible irritation to the skin, such as crumbs or wrinkles
- keep the person's skin clean and dry
- massage pressure areas frequently to stimulate circulation, including bony areas such as the "tailbone," shoulders, heels, elbows
- washable sheepskin or chamois skin may be placed under the person to help absorb moisture, relieve pressure and protect the skin from irritation; foam rubber under bony areas also will help relieve pressure
- encourage good nutrition to help nourish and heal body tissues
- report any redness at a pressure area to the supervisor immediately

To Shampoo in Bed:

Shampoos may be given in bed with the person sitting up or lying on his back. Some persons who have heart disease or conditions that interfere with breathing may need to have the head elevated.

Shampoos are given to clean the hair, improve appearance, increase circulation of the scalp and make the person feel better.

A trough will be necessary to protect the bed and to direct the flow of water from the person's head into a bucket for waste water. A trough may be improvised from a shallow, disposable, rectangular baking pan. Cut a curved piece out from one end and remove the other end. Pad the curved end with a cloth and cover with plastic. The plastic should be long enough to direct water into the bucket. The bed should be protected with newspapers and a plastic sheet. A trough may also be fashioned from six to eight layers of newspaper, with the side edges rolled to the middle and covered with a plastic sheet 36" x 24", rolled to direct the water into the bucket for waste water.

Other equipment needed:
bath towels (2)
liquid shampoo
lemon juice, vinegar or commercial rinse
large pitcher of warm water
bucket or pail

Procedure:

- check temperature of the room
- place towel around the shoulders
- place trough under the head with run-off into bucket on the floor
- apply sufficient water to wet the hair
- work up a good lather, working from front to back of the head
- rinse thoroughly
- work quickly so the person will not be chilled--avoid drafts
- dry with a towel--use dryer if available

Dry shampoo, available at cosmetic counters, may be used. Follow directions on the product. Spray or apply to small sections of the head and brush the hair.

Special Foot Care:

Some persons who are ill for a long time or who have conditions affecting circulation, ambulation or diabetes, etc., may need special care of the feet. Special care of the feet makes the person feel better. The feet should be observed for any unusual appearance. In older people, note reddened or darkened areas on the feet, infections or sores, irritated areas, swelling and discoloration of the nails. Note if there is a difference of temperature between one foot and the other.

Procedure:

- observe feet carefully
- soak the feet first, if only foot care is being given
- clean under the nails
- use pumice stone or emery board to smooth callouses or nails
- if not contra-indicated, massage the feet and legs with lotion to help relax the person and increase circulation; the physician should indicate whether massage is permissible if there is swelling or discoloration
- the aide should not cut or trim the toe nails; this should be done by a professional
- dry carefully between the toes

To Shave a Man:

The purpose of shaving is to add to the comfort and appearance of the individual. Shaving may be done at the same time as the bath. Whenever possible, the man should be encouraged to shave himself. An electric razor is the easiest to use for both the person in bed and the aide. If a safety razor must be used:

- equipment needed includes:
  - . razor with a fresh blade
  - . soap or shaving cream
  - . hot water in a basin
  - . towel and wash cloth

Procedure:

- place a towel over the chest
- wash the face with soap and water, leaving it wet
- rub shaving cream into the beard; if using soap, make a heavy lather
- pull skin tight over the area to be shaved
- with gentle, short strokes, shave in the direction the hair grows
- rinse the razor often
- rinse the person's face and pat it dry

The next skill is giving a back rub. Ask for a volunteer or use a life-sized mannequin. Have each student return the demonstration, giving a back rub.

To Give a Back Rub:

The purposes of giving a back rub are to increase circulation, to relax the person and to increase the person's comfort.

Procedure:

- explain what will be done
- face the head of the bed with the outer foot slightly forward and the knee slightly flexed so that the aide can rock back and forth as pressure is applied to the back
- place the person on his abdomen, preferably
- put lotion or cream in hands to warm and then apply to the person's back
- apply pressure with palms of both hands, beginning at the lower back and moving upward toward the shoulders, using long, firm, but gentle strokes, sweeping upward, outward and downward
- note bony areas and massage gently around them
- assist as needed to put on clean bed clothes

Mouth Care:

Write on the blackboard or flip chart the equipment needed for mouth care at the bedside.

Mouth care is given to provide the person with a feeling of cleanliness and well being, to prevent gum disease and cavities and help lessen bad breath.

Equipment needed:

- soft bristled toothbrush
- towel
- toothpaste (bicarbonate of soda and salt, or dentrifice)
- dental floss
- glass of cool water
- emesis basin or empty container
- drinking straw
- swab
- moisturizer for lips and mouth - optional

Show tray and equipment needed.

Organize the equipment and bring it to the bedside. Place equipment within easy reach of the person so he can do as much of his own dental care as possible.

If the person needs help with brushing:

- explain what will be done
- put the person in an upright position if possible; if not, with the bed flat, turn the person as far toward his abdomen as possible so the saliva and fluids will run out by gravity
- place a towel under his head
- place emesis basin at the side of his head
- gently brush the teeth and tongue
- place the toothbrush at an angle against the gum line
- gently scrub back and forth (wiggle the brush) with short strokes, using this stroke on outer and inner surfaces of each tooth; scrub the chewing surfaces; tilt the rounded front end of the brush to brush vertically the inside of the front teeth and gum tissue.(1)

Demonstrate the angle of the toothbrush, stroke and how to floss. See Exhibit 2.

Procedure for flossing teeth:

- break off approximately 18 inches of dental floss and wrap most of the floss around the middle finger of one hand and the rest around the middle finger of the other hand with about one inch of floss between the hands
- use the thumbs and forefingers to guide the floss; a floss holder may help to reach the back teeth
- gently insert the floss between the teeth; use a sawing motion
- curve the floss into a letter "C" around the tooth when at the gum line
- slide it gently into the space between tooth and gum; hold the floss, curve it around the tooth next to it and scrape it with the floss
- repeat this process for each tooth (2)

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(1) American Dental Association. Cleaning Your Teeth and Gums. 1977.

(2) Ibid.

To Care for Dentures:

The person who has dentures may need help in caring for them. He should be encouraged to wear them most of the time, but they should be removed and cleaned at least once a day.

Procedure:

- wash hands before and after handling dentures
- if the person cannot take them out himself, use a tissue or wipe to lift one end of the denture to break the suction and to pick up the dentures
- place dentures in a container filled with water
- clean the dentures over a basin filled with water to avoid breakage if the dentures are accidently dropped
- use a denture brush or soft toothbrush and cleaning agents such as peroxide or baking soda and water, or the person's preference of cleaning agent
- store dentures in liquid when not in the person's mouth to avoid denture warp
- apply denture cream or adhesive as needed
- bring mouthwash and basin to the bedside so the person can rinse his mouth before the dentures are reinserted

Making an Occupied Bed:

Write on the board or flip chart the equipment and materials needed: Bed--made up: 1 flat sheet (contour sheet optional), 1 pillow case, 1 drawsheet or folded flat sheet--waterproof protector optional. Have each student make part of an occupied bed.

Points to remember about making a bed:

- a clean, fresh bed is an essential part of personal care and grooming for the person in bed

- choose a convenient time for making the bed; after the bath may be a good time

- determine the clean areas on the room in which the clean linen can be placed

- place soiled linen in a bag, hamper, or on a chair protected with newspaper, but never on the floor where it could be contaminated

- store soiled linen in a closed container until it can be laundered

- gather all equipment needed

- to add firmness to the mattress, a board can be placed under the mattress, but check with the supervisor before this is done

- use a bedpad or a waterproof mattress pad if extra protection is needed for the bedding

- blankets should provide adequate warmth but be lightweight

- pillows should be firm enough to maintain body posture but soft enough to be comfortable

To make the bed: (Refer to Exhibit 1.)

- remove the pillows

- loosen the bedding at the foot of the bed and the side at which the homemaker-home health aide is working

- remove the spread, folding it to keep it neat

- remove the top sheet by sliding the top sheet down under the blanket and keep the blanket on the person for warmth

- have the person move to the side of the bed away from the homemaker-home health aide. If there is no helper,go to the other side of the bed and turn the person toward the homemaker-home health aide

- gather the edges of the soiled bottom sheet lengthwise to make a flat roll and push it and the drawsheet under the person's head, back, and legs

- smooth the mattress pad

- place the clean bottom sheet folded lengthwise on the mattress pad, leaving approximately 18 inches at the head of the bed to secure the sheet

- push the edges of the clean sheet at the center of the bed under the soiled sheet

- make a corner at the head of the bed by:

    - grasping the selvage edge of the clean sheet hanging at the side of the bed, lift it up until it forms a straight line against the mattress. Place it across the bed to form a triangle.

    - tuck under the mattress the portion of the sheet hanging down at the corner of the bed

    - bring the triangle over the side of the bed, smooth, and tuck it under the mattress

- if using a drawsheet, center it and tuck one side under the mattress as the sheet is tucked in

- gather the edges of the sheet, smooth, and tuck it under the mattress along the entire side

- have the person roll or slide to the clean side of the bed
- go to the other side of the bed and loosen the bedding
- remove the soiled bottom sheet, keeping the soiled surface on the inside; place it in the area for soiled linen
- add top sheet, spread and clean pillow case

Procedure for changing the pillowcase:

- remove the soiled pillowcase by turning it inside out, as it may carry infection from the person's nose and mouth; the aide should keep the case away from her face and put the case with the soiled linen
- place both hands in the clean case to free the corners; remove hands from within the case
- with the hand, grasp the outside of the case at the center seam and turn the case back over the hand
- with the free hand, pull the case over the pillow, fit the corners and smooth the case

A footboard or cradle may be used at the foot of the bed to take the weight of heavy covers off the feet and legs. An improvised cradle may be made from a cardboard box by cutting out sections so that the box will fit comfortably over the person's legs. The cradle may also be used as a bed table.

In some homes, bed linens may be limited or unavailable. The aide should discuss adaptation with the individual or a family member. Clean warm blankets may be used in place of sheets. Elderly people sometimes prefer cotton blankets. If it is a problem of laundry, ask that a family member do the laundry if this is not a part of the plan. Sometimes bedding may be washed and dried while the person is sitting up if laundry facilities are convenient as in an apartment building or in the home. If there is no bedding, this should be reported to the supervisor so that arrangements can be made to secure the minimum necessary to the care of the individual.

A clean, wrinkle-free bed will do much toward making the person more comfortable and prevent skin irritation. This is done preferably after the bath so the person is also clean and the bed does not get wet should the person be taking a bed bath.

SELECTED REFERENCES

American Dental Association. "Cleaning Your Teeth and Gums." Chicago: American Dental Association, 1977.

American Dental Association. "Happiness is a Healthy Mouth." Chicago: American Dental Association, 1976.

American Red Cross. Family Health and Home Nursing Textbook. Garden City, New York: Doubleday. 1979.

American Red Cross. Home Nursing Instructors Guide. Washington, D.C.: American Red Cross. 1979.

DuGas, Beverly Witter, R.N., M.A., Ed.D. Introduction to Patient Care. 3rd ed. Philadelphia: W.B. Saunders Co., 1977.

Family Safety. "Check Your Home Safety Sense." Vol. 36, No. 1. National Safety Council. Spring, 1977, pages 18-19.

Henderson, Virginia and Gladys Nite. Principles and Practice of Nursing, 6 ed. New York: Macmillan Company. 1978. P. 732.

Maurer, Jean. The Nursing Clinics of North America. "Providing Optimal Oral Health." Vol. 12, No. 4. Philadelphia: W.B. Saunders Co., 1977, pages 669-685.

Thompson, Ella M., R.N., B.S., and Caroline Bunker Rosdahl, R.N., M.A. Textbook of Basic Nursing. 2nd ed. Philadelphia: J.B. Lippincott Co., 1973.

U.S. Department of Health, Education and Welfare. "Feet First." Washington, D.C.: Government Printing Office, 1970.

Wood, Lucile A., R.N., M.S., and Beverly J. Rambo, R.N., M.A., M.N. (eds). Nursing Skills for Allied Health Services. Vol. 1. Philadelphia: W.B. Saunders Co., 1977.

VISUAL AIDS

"The Bed Bath." 16 mm, black and white film. University of Iowa, Ames, Iowa.

"Preventing Pressure Sores." Slides and cassette. 1974. Sister Kenny Institute, Minneapolis, Minnesota.

Trainex Film Strips. Several of the training programs that tested the Model Curriculum found this series of film strips useful. These may be obtained from the company or borrowed from schools that prepare nursing personnel--i.e., nurses' aides, practical nurses or professional nurses.

Specifically designed for care of the sick at home are the following film strips, at $75 each:

Program Order No.	
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472	"Taking the Patient's Temperature--Oral and Rectal Procedures"
474	"Moving and Turning the Patient"
477	"Positioning the Patient for Comfort and Safety"
475	"Giving the Patient a Bed Bath"

Order the above film strips from:

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Order No. 5127 "Basic Patient Care: Comfort Hygiene"

The address for ordering is:

Concept Media
1500 Adams Avenue
Costa Mesa, California 92626

ASSESSMENT

Please write the word True if you think the statement is true and False if you think it is not true.

1. ________ Safety and comfort are principles that should be observed when giving personal care to a person.
2. ________ We should bend from the waist to pick up or move an object.
3. ________ A homemaker-home health aide should give support to the curves of the spine with a pillow under the head and neck of the person.
4. ________ Body wastes are eliminated through the kidneys and bowels only.
5. ________ Provide privacy when the person wants to use the bedpan or urinal.
6. ________ A purpose of giving a bath is to stimulate body circulation.
7. ________ A homemaker-home health aide should give a person a bath every day.
8. ________ We should let the person do things for himself as much as he can.
9. ________ Flossing is one method of getting rid of food particles between the teeth.
10. ________ Dentures may be stored by simply wrapping them in tissues and putting them at the person's bedside.
11. ________ Keeping the beddings free from crumbs and wrinkles is one method of preventing pressure sores.
12. ________ The male patient needs to be shaved every day whether he likes it or not.
13. ________ A principle of good mechanics is to stand on a broad base of support when lifting anything heavy.
14. ________ A person who is bedridden should have his position changed every three hours.
15. ________ Good posture makes us feel good.

ANSWERS

1. T

2. F

3. T

4. F

5. T

6. T

7. F

8. T

9. T

10. F

11. T

12. F

13. T

14. F

15. T

AIDS

Exercise 1: Bedmaking Practice

Exercise 2: Confinement and Human Needs

Exhibit 1: Bed Bath

Exhibit 2: How to Brush Your Teeth

Exhibit 3: Changing the Bottom Sheet

Discussion Questions 1: Care of a Person in Bed

Exhibit 1: Bed Bath

PREPARATION

FACE, NECK, AND EARS

CHEST AND ABDOMEN

ARMS AND HANDS

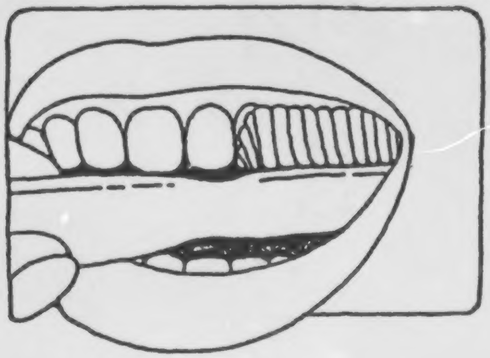
LEGS AND FEET

BACK OF NECK, BACK, AND BUTTOCKS

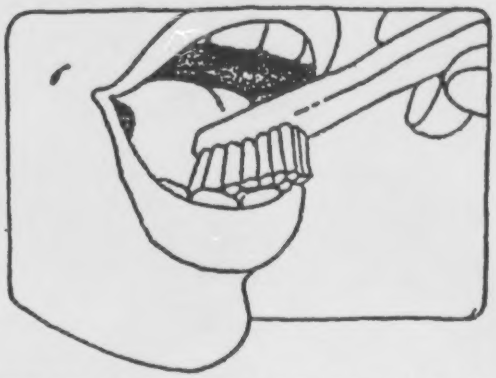
EXTERNAL GENITALIA

AFTER CARE

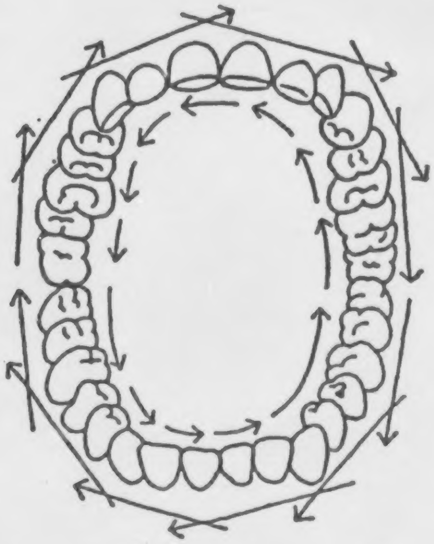
How to Brush Your Teeth.



Place the head of your brush alongside your teeth, with the bristle tips angled against the gum line.



Brush the insides of front teeth with the "toe" (front part) of the brush.



Brush the outsides and the insides of your upper and lower teeth.

EXERCISE 1. Bedmaking Practice

This exercise provides for practice in making occupied beds. Since the homemaker-home health aide trainees will both make beds and be the person in the bed, they are provided with practice and feedback on the impact of their tasks.

- Divide the homemaker-home health aide trainees into small groups. Each group will require two sets of bed linen and one bed.
- The groups are asked to alternate being the person in the bed, the homemaker-home health aide changing the bed, and observers.
- Ask groups to discuss the steps in bedmaking.
- Ask the trainees to comment on how it felt to be the person in the bed.
- The initial bed making will be of an unoccupied bed. Thereafter as roles are alternated the beds will be occupied.
- After each bedding change is completed the "soiled" linen should be refolded for the next aide to use.

EXERCISE 2: Confinement and Human Needs

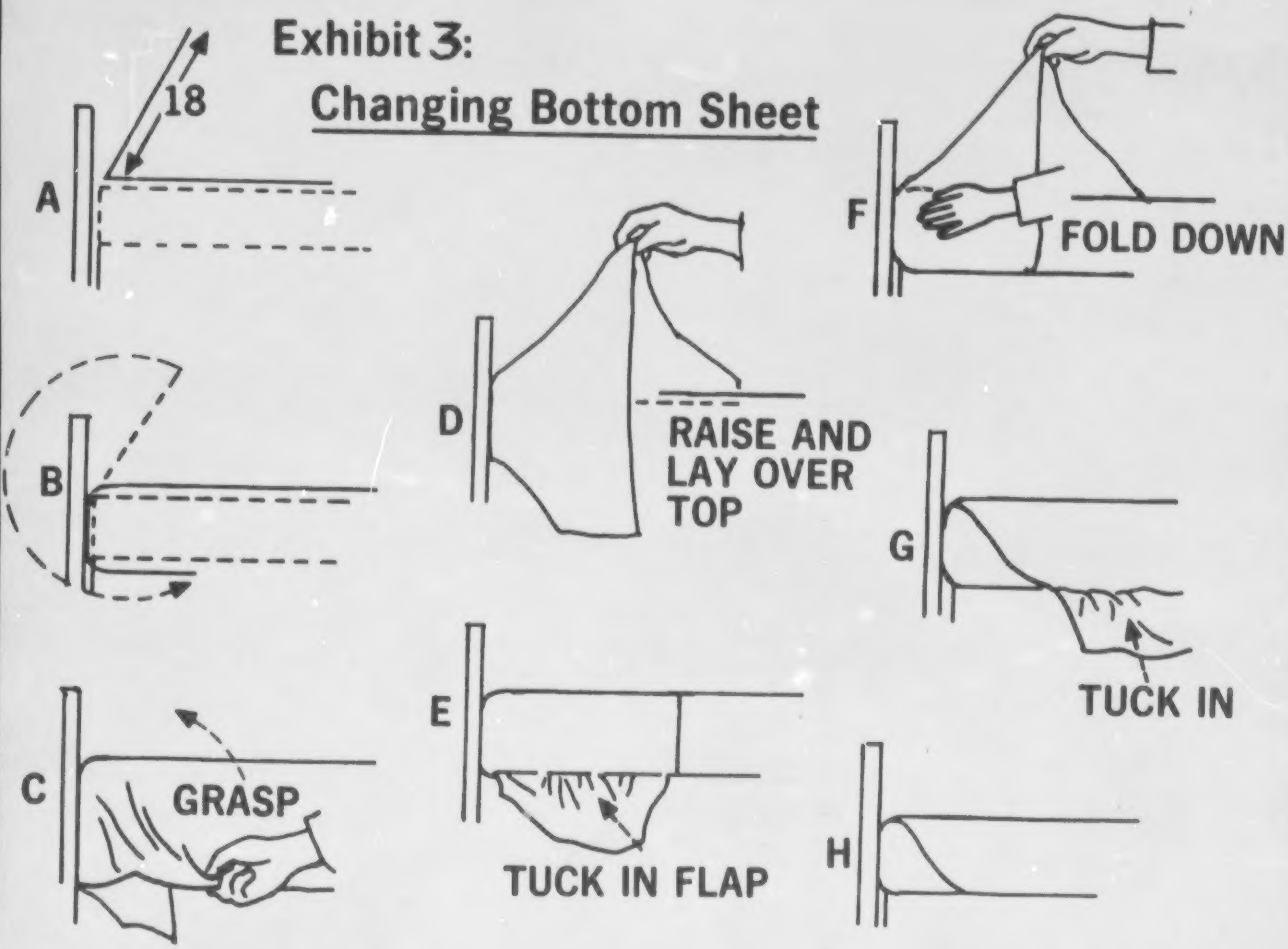
This exercise explores how people feel when confined to bed with many of their basic needs being met by someone else.

- Have trainees generate a list of basic needs and record on a chart or board.
- Ask them to indicate which needs an individual confined to bed can meet himself and which must be met by someone else.
- Discuss how feelings of decreased autonomy and ability to take care of personal hygiene, etc. could affect the confined person.
- Describe the homemaker-home health aide's role and responsibility.

Discussion Questions 1: Care of a Person in Bed

1. Discuss some of the reasons a person might be confined to bed.
2. What types of information would the homemaker-home health aide find on the care plan that would help her in giving personal care?
3. Discuss the principles of good body mechanics.
4. What important areas of the body should be supported?
5. Why is it important to change positions frequently?
6. What steps may be followed to help establish good bowel and bladder patterns of elimination?
7. What is accomplished in giving a person a bed bath?
8. Why is mouth care given?
9. What points are important in making a bed that relate to skin care?

Exhibit 3: Changing Bottom Sheet


18
A
B
C
GRASP
D
RAISE AND LAY OVER TOP
E
TUCK IN FLAP
F
FOLD DOWN
G
TUCK IN
H

UNIT E: CARE OF THE PERSON NOT CONFINED TO BED

ESTIMATED TIME: 1-1/2 hours

SUGGESTED INSTRUCTOR: Professional Nurse

INTRODUCTION

In this unit information is presented which deals with care of the person who is not confined to bed. Included are transfer activities and helping the person with mobility, hygiene and grooming. Safety factors as they relate to the person and the environment are stressed.

The trainee will be able to:

- prepare for and assist with personal care activities related to hygiene and grooming
- make an unoccupied bed - optional
- assist the person with need for elimination
- assist in ambulation to help the person move to and from a bed, chair and tub
- identify safety hazards in the person's environment

MATERIALS/EQUIPMENT

bed

chair

blanket (to be used as a robe)

foot stool

CONTENT

Part 1: Getting Out of Bed

This unit explores an assisting role for the homemaker-home health aide in giving personal care when the person is able to be out of bed. The demonstrations include methods for transfering the person to and from the bed, tub and chair.

The health care team plans the activity in which the person may engage. Usually the plan of care includes how long the person may be out of bed. It is very important that a person getting up for the first time be closely supervised as he may be weak and could easily fall and injure himself.

Some of the advantages of increased activity are:

- muscle tone is improved, and muscle weakness prevented
- contractures and deformities are prevented
- the recovery period is frequently shortened
- circulation is improved
- the need for sedatives usually decreases
- elimination of body wastes improves
- appetite usually improves

Although safety was considered in Section III, additional precautions are needed when there is an ill or disabled person in the home. It is very important to assess safety factors at all times, but especially before the person starts to walk again. In addition to assessing the immediate environment in the bedroom, check the floors, stairs, hallways, the bathroom and kitchen where the person may be walking. Clear the stairs, hallways and floors of clutter and toys. Check the stairs to see that there is a non-skid surface, that edges of the steps are marked, especially for older people, and that the stairway is well lighted. Check the stair handrail for firmness. The halls should be well lighted. Suggest the use of night lights in the person's room, in the hallway and in the bathroom if there are none. A flashlight, by the bed, is also useful. Lighting should be brighter for older people as the ability to see lessens with age. *(See Handout 3, Section III-A.)*

Small loose rugs should be removed and stored. Check to see that there are no loose tiles or carpets to cause a fall. Floors should not be so highly polished as to make walking hazardous.

Grab bars as well as non-skid strips should be used in the bathtub if a tub bath is to be given. Grab bars at the toilet may also be needed, depending upon the degree of disability. These should be firmly attached to the wall for the person's safety.

Be sure emergency telephone numbers are posted clearly by the telephone(s). Include telephone numbers for the rescue squad, fire, police, physician and poison control center.

These reminders will help reduce hazards in the home and make it a safer environment for not only the person who is ill, but for all of the family members and guests.

Part 2: Getting Up In A Chair

Steps for sitting up and transfer to chair should be demonstrated with a volunteer.

The health plan or the supervisor will indicate when it is safe for the person to sit up and get out of bed. Sitting up gives the individual a feeling of "getting better" and is the first step toward regaining independence. After the environment has been evaluated, and it has been determined safe to get the person up, the following steps are suggested to help the person sit up in bed and then transfer to a chair.

Before attempting to get the person out of bed, he must be able to sit up without feeling dizzy or having a great increase in the rate, or change in the rhythm of his pulse. The person should also be strong enough to transfer from the bed to a chair before attempting to walk.

Procedure for teaching the person to sit up:

- explain the steps first
- have the person roll to one side, facing the edge of the bed
- gradually drop legs over the side of the bed while pressing down on the bed with the elbow nearest the edge of the bed
- change weight to the hand and push down to bring shoulders to an upright position. At the same time, push down with the other hand to give leverage.

Procedure for helping the person to sit up:

- explain what will be done
- help the person flex his knees
- stand facing the head of the bed with the outer foot forward
- lock arms with the person by putting the near arm under the person's near arm with the hand on his shoulder
- on signal, rock backwards pulling the person to a sitting position
- check to see if the person is dizzy; if so, continue to provide support to the person

- if dizziness persists beyond a few minutes, the person should be returned to a flat position in bed. (Some dizziness may be expected after the person has been flat in bed)

- when he is able, show him how to support himself with his arms braced behind him

- record how the person reacted to sitting up in bed. Note if he had a change in the pulse rate or rhythm and if he had dizziness, and how long it lasted

A footstool may be needed if the bed is too high for the person's feet to reach the floor while sitting on the side of the bed. A footstool can be made by taping large juice cans together. Pad with cotton or soft material such as nylon hose. Tape cardboard to the sides and top of the cans. Cover the stool using a towel or plastic adhesive cloth. Attach non-skid strips to the bottom to keep the stool from slipping.

An improvised bathrobe can be made from a blanket by making a fold of approximately 6-8 inches along the length of the blanket to serve as a collar. Pull the ends of the blanket forward over the person's shoulders and fasten the ends together in front with a safety pin. Center an end of the blanket over each wrist, turning back several inches to make a cuff.[1]

Have each trainee practice helping a person to sit up in bed. (See Exercise 1.)

The next demonstration is the standing transfer of a person to a chair. This method applies to a chair or wheelchair. This procedure should be supervised when done for the first time in field practice.

Procedure for transfering a person from the bed to a chair:

- explain what will be done

- assist the person as needed to put on shoes or sturdy slippers

- use a sturdy chair with arms and a seat low enough to allow the person's feet to solidly touch the floor. If using a wheelchair, make sure it is also sturdy and in good condition.

- place the chair parallel to the bed on the person's strongest side facing him at a slight angle. If using a wheelchair, lock brakes and push footrests out of the way [2]

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[1] American Red Cross Family Health and Home Nursing. New York: Doubleday & Company, Inc., 1979, p.524.

- stand in front of the person to assist him if he should fall
- instruct him to lean forward slightly, push down on the bed with his hands, straighten his legs and stand up[3]
- tell him to take small steps while turning his back toward the chair, until the back of his legs touch the chair
- have him take hold of the arm rests and lower himself into the chair, leaning slightly forward as he sits down
- have him slide his hips back into the chair and sit squarely for good body alignment[4]
- reverse the process for getting out of a chair
- record on the daily care plan or record how the person reacted to sitting up, to the transfer, and if he was able to sit up for the time prescribed

Several alternative methods of transfer may be shown at this time if desired.

Divide the group of trainees into pairs. Have one act as the homemaker-home health aide and the other as the person receiving care. Have each trainee practice helping a person into and out of a chair.

Part 3: Helping A Person To Walk

The skill to be demonstrated is helping a person to walk. Have each trainee demonstrate how to walk with a person who is walking for the first time after an illness.

Walking may need to be relearned. After the person is able to sit up, get out of bed, and in an out of a chair, he may feel strong enough to attempt walking. The supervisor will indicate when the physician feels the person is ready to walk. The person will have regained most of his strength before walking is attempted. The homemaker-home health aide's assessment of the person's reactions to other activities, however, can help considerably in determining when increased activity should be tried. The person who is walking after being in bed needs to be watched carefully.

2, 3, 4: Sine, Robert D. (ed.) et.al. Basic Rehabilitation Techniques. Germantown, MD: 1977, p.67.

This procedure should be supervised when the trainee does it in field practice.

Procedure and caution to be used with an ill and weak person:

- explain to the person what is to be done
- have the person wear sturdy, low-heeled shoes with non-slippery soles
- have the person practice standing using support to help maintain balance
- next, have him practice shifting weight using firm supports on either side; two chairs may be used
- walk with the person as he begins to walk. If there is no disability, have him wear a securely fastened belt, to provide a good grip for the homemaker-home health aide. This helps provide stability and if he becomes faint, he can be pulled against the homemaker-home health aide for support, and eased to the floor sliding along her body.
- if there is one-sided weakness, walk on the weak side and slightly behind the person. Put the far hand on the hip on the strong side and the other hand in front of the person's shoulder on the weak side. His shoulder can be pulled back and his hips forward to help his alignment, or he can be pulled back against the homemaker-home health aide and eased gently to the floor if he becomes faint and cannot be held.[5]
- help the person follow his normal walking gait
- a cane or walker may assist the person as he relearns walking (see Unit G)
- record the person's physical and emotional reaction to walking

The person who is able to be up and walking will feel he has much more control over what is happening to him, and his feeling of independence increases. He usually will feel he has made good progress toward improving his state of health.

Part 4: Hygiene and Grooming for the Ambulatory Person

This procedure should be supervised when the trainee is doing field practice. Some agency policies may not include the tub bath as an allowable procedure for the homemaker-home health aide.

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[5] Ibid., pp.83-84.

The person who is able to be up should be encouraged to do as much of his personal care as he can. Many people have a real sense of accomplishment in being able to take a shower or tub bath. This also provides exercise and stimulates circulation. A tub or shower should be considered only if the person is strong enough, and if it is included as part of the care plan.

Special concerns in providing a safe bath:

- prepare the water and room before the person comes to the bathroom. Test the water on the inner wrist to be sure it will not burn the person. The skin of the elderly person may not be sensitive to the water temperature. Hot water dialates the blood vessels and so decreases blood pressure. Thus increasing the elderly person's risk of blacking out, becoming dizzy or confused

- assure that the room is warm and supplied with soap, washcloth and towel. A small rubber-tipped stool to sit on in the tub or shower is desirable. A rubber mat may be placed in the bottom of the tub or shower to keep the person from slipping

- aviod bath oils in the tub. These will make the tub surface very slick and increase the risk of falling

Procedure for transfering to the bathtub:

- explain what the procedure will be

- place a straight chair or wheelchair facing the tub

- allow room for the person to lift his legs into the tub

- steady the chair, lock the brakes if a wheelchair is used

- have the person lift or help him lift one foot at a time over the side of the tub

- have the person hold onto the grab bars or side of the tub and slide carefully off the chair onto the edge of the tub. If he needs help, support his body around the waist from behind. (A sheet or strong belt may be placed around the waist for firm support, if needed

- have the person move from the tub's edge onto the stool placed in the tub, giving help as needed. (A chair may be used instead of a stool.) Or, help him lower himself carefully into the water as he continues to hold the grab bar and tub edge

- wash and dry, providing help as needed

- drain the water out of the tub before the person stands up

- place chair facing the tub

- to get out of the tub, have the person take hold of the grab bar, supporting him around the waist if needed, and helping him to a sitting position on the edge of the tub

- help him to a standing position and follow the procedure for sitting in the chair as demonstrated previously

If the person is weak after his bath, he should return to bed to rest. Complete grooming and other personal care, such as brushing teeth, etc., can be done when he is feeling better (refer to Unit D). If he feels able, grooming aids can be brought to the bathroom.

The bed may be made and the room straightened or cleaned while the person is sitting up or having a bath. It is easier to make the bed while the person is not in it.

SELECTED REFERENCES

American Red Cross. Family Health and Home Nursing Textbook. Garden City, New York: Doubleday & Company, Inc. 1979.

American Red Cross. Home Nursing Instructors Guide. Washington, DC: American Red Cross, 1979.

Sine, Robert D., M.D., Shelly E. Liss, M.D., Robert E. Roush, Ed.D. and J. David Holcomb, Ed.D. (eds.) Basic Rehabilitation Techniques. Germantown, MD: Aspec Systems Corporation, 1977. Pp.67-84.

The Canadian Red Cross Society. Care in the Home. Toronto, Canada: The Canadian Red Cross Society, 1971.

Wood, Lucille, R.N., M.S.,and Beverly J. Rambo, R.N., M.A., M.N. (eds.) Nursing Skills for Allied Health Services. Vol.1. Philadelphia, PA: W.B. Saunders Company, 1977.

ASSESSMENT

INSTRUCTIONS: Please provide answers to the following questions by writing your answers on the blanks provided.

1 - 3. The health professional usually wants to get the person out of bed as soon as possible. Name three benefits that can be derived by the person from this activity.

____

4 - 7. It is important that the homemaker-home health aide checks the immediate environment for safety before the person walks about. Name four things to check before the person begins to walk.

____

8 - 10. What emergency numbers should be available and posted clearly by the telephone?

____________________ ____________________

____________________ ____________________

____________________ ____________________

11 - 12. Helping the person in and out of the bathtub involves some skill. To insure the safety of the person, the homemaker-home health aide should check if the tub is equipped with these safety devices.

____

____

____

____

13. The homemaker-home health aide should encourage the person to do most of the personal care grooming for himself. Give the purpose of this.

____

____

ANSWERS

1. Improves circulation
2. Prevents contracture and deformities
3. Improves body elimination

Others: Improves person's morale, lessens use of sedatives, etc.

4. Remove all clutter in the room, hallways, stairs, etc.
5. Check halls that they are well lighted
6. Provide non-skid backed rugs
7. Have grab bars installed, if not available

Others: Check for loose connections of electrical applicances.

8. Rescue squad
9. Fire department
10. Poison control center

Others: Doctor's name, hospital, etc.

11. Grab bars
12. Non-skid rubber mat
13. Develop person's strength, self confidence, independence

AIDS

EXERCISE 1: Skills Practice

Discussion Question 1: Care Of A Person Not Confined to A Bed

Exercise 1: Skills Practice

This exercise provides for practice in helping a person sit up in bed, to get into and out of a chair, and help the person walk.

- Divide the trainees into small groups or pairs.
- Each person is asked to alternate roles of the aide or the person receiving the service.
- Demonstrate each of the three skill areas.
- Have the groups practice and provide each other feedback.
- Ask the trainees to comment on how it felt to be the person receiving the assistance.

Discussion Question 1: Care of a Person Not Confined to a Bed

1. What are some of the advantages of increased activity.
2. Discuss safety factors that should be considered in the home.
3. Discuss the importance of following a sequence of activities when getting a person out of bed.
4. Discuss why it is important for a person to practice balance before walking again.
5. What are the safety factors to be considered when moving a person in and out of the bath tub?

UNIT F: OBSERVATIONS ABOUT MEDICATIONS

ESTIMATED TIME: 1/2 hour

SUGGESTED INSTRUCTOR: Professional Nurse, Pharmacist

INTRODUCTION

The homemaker-home health aide does not administer drugs to individuals but needs information about drugs because of the many people receiving service who will be taking drugs. This unit describes information about the use of, caring of, and disposing of medications and the information contained on the label. It is also important that the homemaker-home health aide be able to prevent drug error, observe reactions, and prevent misuse of drugs.

EXPECTED OUTCOME

The trainee will be able to:

- observe and report how medications are taken, including any unusual reactions
- suggest methods of avoiding drug error
- store medication correctly
- dispose of old medication correctly.

SUGGESTED MATERIALS/EQUIPMENT

Samples of liquid, tablets, capsules, bottle with dropper, ointments, and vaginal and rectal suppositories.

CONTENT

Part 1: General Information about Medications

Show samples of types of medications. Stress that the homemaker-home health aide will not give medications but will learn how to store and dispose of medications and how to observe that the person takes his medication and any unusual reactions.

Many of the sick and elderly persons that receive homemaker-home health aide services will be taking one or more medications. Therefore, some basic concepts regarding drugs are important in providing responsible health support services.

Most medications are potent substances. They are used to help a person to recover health or to maintain normal body functions. A serious or fatal result could occur if there is an allergy or if the medicine is taken incorrectly. Sometimes the medications, even though taken correctly, may not have the desired results.

Medications that may be obtained only with a written order from a physician are called prescription drugs. Medications that may be obtained without written order are called nonprescription, or over-the-counter, drugs. For example, penicillin is a prescription drug and aspirin is a nonprescription, or over-the-counter (OTC), drug.

When a person takes a medication prescribed by a doctor, it is very important that other medicine not be taken unless the doctor knows about it. This includes over-the-counter medication as well as drugs prescribed by the doctor. The action of some medicines is changed when taken with other medications. There could be serious results, or the drug might be ineffective. Certain foods change the reaction of specific medicines. The medication bottle will usually contain a warning about what food to avoid. In addition, the supervisor will tell the homemaker-home health aide what food should not be served.

Medication is prescribed by a doctor for a person for a particular illness. The prescription is a written order which usually includes the following information on the prescription label.

Write the following on the board as a prescription example:

- name and dosage of the medication
- the amount of the medication ordered
- name of the person for whom the medication is prescribed
- amount to take each time and when, such as after meals
- how often to take the medication
- the doctor's name and Drug Enforcement Administration (DEA) number if it is a controlled drug, such as a narcotic
- the date
- prescription number
- name, telephone, and address of the pharmacy
- precautions or special instructions about what to take with the medication
- the number of times the prescription can be refilled
- special storage instructions.

Part 2: Observations, Reporting and Safety in Relation to Medication

Although the homemaker-home health aide does not give medications, certain responsibilities relate to the use of drugs. This includes observation, reporting and safety. Handout 2 is an example of how pharmacists monitor a person's drugs to prevent drug errors and the use of incompatible drugs.

- The nurse will make out the medication schedule for the person to follow. The homemaker-home health aide will not give the medications but will observe whether the person takes the medication, and the effect of the medication, record the observations, and report to the supervisor anything that appears to be a problem
- The person should follow directions carefully regarding the amount and time of day for taking the drug and whether certain liquids or foods are to be taken or avoided
- Be sure the person has told the doctor whether other medication is being taken. This includes other prescriptions and over-the-counter drugs. As an added precaution, the homemaker-home health aide should report to the supervisor or health team member if other drugs are being taken. A valuable record which many pharmacies maintain is a patient drug profile. The pharmacist records the drugs prescribed for the person. This record helps the pharmacist and the physician assure the person that the drugs are compatible.
- Immediately report to the supervisor any unusual reactions such as itching, stomachache, diarrhea, nausea, vomiting, rash, hives, headache, confusion, or other signs or symptoms. Report if the person is not taking medications as ordered or vomits after taking medication
- Immediately report to the supervisor if the person is taking more medication than prescribed
- If more than one person is taking medication in the household, keep the medications in separate places, to avoid a person's taking the wrong drug
- To avoid overdose, it may be necessary to place each daily dose in a separate container. Such precautions are espeally important when persons are elderly, have limited vision, or are confused at times
- Give the person water or other liquid, if allowed, to help in swallowing the medication
- Record on the person's care plan whether the medication is taken, date, time, amount, manner, and remarks about responses to the medication.

Write on the board or flipchart what a sample medication schedule looks like. Explain how to record on the person's care plan any observations about the medication.

Medicine	Date	Time	Amount and Manner	Response
Prescription #4290	3/4	9:00 AM 1:00 PM 5:00 PM	One tablet by mouth	No reaction

The next section deals with storage and disposal of medications and bridges concepts of safety mentioned earlier in the unit.

Medications must be carefully stored to protect young children and to help ensure effectiveness and safety in the use of medications.

- Be sure that all medications are out of the reach of children. If there are older people who are not responsible for their actions, or children in the home, it is advisable to keep medication in a locked cabinet. This includes aspirin and even iron tablets which if taken by a child in quantity could be fatal
- Check to see that medications marked for refrigeration are stored in the refrigerator in an area in which they will not freeze and in which they cannot be easily reached by children
- Check to see that medications are stored away from light and heat as a change in the chemical composition may result
- When someone is taking medicine, be sure that there is a good light so that the medicine label can be seen clearly
- Medications should not be moved within the medicine cabinet or storage area. People expect medication to be in a certain place and do not always look at the label
- Consult the supervisor and the family about destroying unlabeled medicine, a label that cannot be clearly read, or that is outdated
- Medications should not be used if label is missing
- Be sure that clear medications that look like water or soft drinks are not put in containers from which children might drink

- Post by the telephone, telephone numbers of the poison control center, the rescue squad and the doctor (Unit E)

The safe disposal of medicine is carried out in several ways:

- Flushing down the toilet (open capsules that may float in a bowl without a strong flushing action, and some liquids may stain the toilet bowl)

- Burning in an incinerator

- Putting in the garbage disposal

Do not put medications to be disposed of in the garbage or trash where children and animals can get hold of them. Always check with the supervisor before disposing of drugs.

Part 3: Drug Misuse

The instructor may use available publications if a more in-depth discussion is indicated because of possible homemaker-home health aide involvement in problems of drug abuse.

Drugs have important uses in restoring and maintaining health and relieving pain and other symptoms of illness. Proper drug use is taking a drug for its intended purpose in the recommended amount, frequency and strength. A drug is misused when it is taken for the intended purpose but not in its appropriate amount or frequency. Misuse of drugs may develop intentionally or unintentially. Sometimes a person who is ill for a long period of time can become dependent on certain drugs, especially those used for pain and tranquilizers.

The homemaker-home health aide may observe overuse or misuse of drugs by persons receiving service and other family members. This may be dangerous to the person(s) health and indicate a need for medical attention and reporting to the supervisor.

In other instances the homemaker-home health aide may observe behavior of family members that is suggestive of drug dependency, such as:

- Impulsiveness and taking risks

- Relating poorly to family members and other persons

- Being secretive

- Having low self-esteem

- Wanting immediate gratification of desires

- Abusiveness.

Part 4: Safe Use of Oxygen

If possible, demonstrate to or show the trainees how oxygen may be used in the home with safety.

Oxygen may be ordered by the doctor to help the person breathe. As part of the treatment, it may be dispensed by use of an oxygen tent, a breathing machine, through a mask or nasal tube, or the person may have a portable tank containing liquid oxygen. Because of the danger of fire, the homemaker-home health aide should help the individual and family practice safety precautions when oxygen is being used.

Some safety precautions are:

- Keep the room in which it is used closed off from the rest of the house
- Allow no smoking, lighting of matches, or use of a gas heater in the room because of the danger of fire
- Place "no smoking signs" inside and outside the room to remind others
- Use cotton carpets, rugs, clothing, and bedding as nylon builds up static electricity, which could result in a fire
- Use of a humidifier will help reduce static electricity and the drying effect of oxygen
- Store oxygen tanks in a cool area
- Tanks must be secured in the floor stand provided by the company.

SELECTED REFERENCES

American Red Cross. Family Health and Home Nursing Textbook. Garden City, NY: Doubleday & Company, Inc., 1979.

American Red Cross. Home Nursing Instructors Guide. Washington, DC: American Red Cross, 1979.

Hill, Margaret. Drugs - Use, Misuse, Abuse Guidance for Families. Public Affairs Pamphlet, 381 Park Avenue South, New York, NY 10016: (Pamphlet No.515.)

The American Pharmaceutical Association. Teaching Manual for Pharmacists Providing In-Service Training. The Right Drug to the Right Patient. Washington, DC: The American Pharmaceutical Association, 1977.

Thompson, Ella M., R.N., B.S., and Caroline Bunker Rosdahl, R.N., M.A. Textbook of Basic Nursing. 2nd Edition. Philadelphia: J.B. Lippencott Company, 1973.

What Everyone Should Know About Drug Abuse. A descriptive booklet Greenfield, MA: Channing Bete Co., Inc., 1978.

ASSESSMENT

Instructions: Please match the following by putting the letters of the right column in the blanks provided in the left column.

1. ____A health professional who writes a prescription
2. ____Terms for medicines that one can purchase without a perscription
3. ____A very special precaution to be observed when a person is taking oxygen
4. ____A safety precaution to observe in destroying medicines
5. ____A health professional who dispenses medications and can provide information if one has questions about certain drugs
6. ____Label of this drug will include the doctor's name and an indication of the Drug Enforcement Administration (DEA) number
7. ____To make sure that the person takes his medicine
8. ____A very important procedure before doing any skill
9. ____A record which helps assure the person the drugs he's prescribed can be safely taken together
10. ____Person to whom the homemaker-home health aide refers any questions about drug side effects
11. ____A record showing when medications should be taken which is made out by the nurse

A. Wash hands carefully

B. Patient drug profile

C. Physician

D. Brand name

E. Over-the-counter drugs

F. Pharmacist

G. Stay with the person until he swallows the medicine

H. Drug schedule

I. "No Smoking" sign inside the room

J. Supervisor

K. Aspirin is the generic name

L. Do not put drugs in garbage or trash where children and animals may find them

M. Suppositories

N. Narcotic

O. Reading the label

ANSWERS

1. C
2. E
3. I
4. L
5. F
6. N
7. G
8. A
9. B
10. J
11. H

Exercise 1: Understanding the Homemaker-Home Health Aide's Responsibilities

The purpose of this exercise is to assist the homemaker-home health aide understand his or her appropriate role regarding medications. Since the homemaker-home health aide will not be administering medications, it is important to understand why and the agency's actual limitations.

- Discuss the agency's specific policies and procedures concerning medications

- Suggest various situations where the homemaker-home health aide will have to know the policy and be able to respond

Examples:

- A person confined to bed asks the homemaker-home health aide to get her medication because her husband left it in another room

- An elderly person asks for assistance with his eye drops because his unsteady hands prevent him from being able to administer them properly

- A homemaker-home health aide observes medication left where small children could easily reach them or medication labelled "Keep Refrigerated" is left out

- A person seems confused about which medication should be taken. A written schedule has been prepared by the physician, but the person says he does not understand it

- The homemaker-home health aide sees the individual place the bottle of medicine on the window sill so that it will be easy to reach

- Mr. Roberts is seen taking two pills for fluid retention instead of the one indicated on the prescription bottle. He tells the homemaker-home health aide that he had trouble getting his shoes on in the morning because of more swellings so decided to take an extra pill

- Mr. and Mrs. York are in their 80's. Both of them are taking several medications which they keep on the kitchen shelf so they will "be handy" to take before or after meals as indicated on the prescription labels

Discuss the appropriate role, responsibilities, and reporting requirements of each situation.

AIDS

Exercise 1: Medication: Homemaker-Home Health Aide Role

Discussion Questions 1: Understanding the Homemaker-Home Health Aide's Responsibilities Concerning Medications

Handout 1: Medication Schedules for Observation of Individual Taking Drugs

Handout 2: Personal Drug Information Check List

Discussion Questions 1: Understanding the Homemaker-Home Health Aide's Responsibilities Concerning Medications

1. Why should a person not take any medications without the knowledge of his physician?
2. What is a patient profile and what service does it provide?
3. Discuss the reasons behind why homemaker-home health aides would generally not administer medication.
4. Discuss the reasons that homemaker-home health aides would generally not administer medication.
5. What is a safe way to store medications?
6. How and why should medications be destroyed?
7. What should be done if a person appears confused with medications?
8. How should you respond to requests for assistance with medications?
9. When and what should be reported to your supervisor about medications?

Handout 1: Medication Schedule

A simplified record on which a homemaker-home health aide may note when medications are taken and any problems if a home care record is not available in the home.

Medicine:	Medicine:	Medicine:
Heart pill (1 a day)	Vitamin (1 a day)	Aspirin for arthritis (2 - 4 x a day)
Taken	Taken	Taken
Time Day	Time Day	Time Day

American Red Cross

Nursing and Health Services

PERSONAL DRUG INFORMATION CHECKLIST

Patient's name ______

Date ______

Pharmacist ______

Pharmacy ______

Pharmacy telephone ______

Physician ______

Physician's telephone ______

To the pharmacist: Use this form in counseling the patient about his medications.

To the patient: Use this form to assist in asking for information about your medications.

Adapted from "The Right Drug To The Right Patient," copyright 1977 American Pharmaceutical Association. Prepared in cooperation with APhA. Adapted with permission.

Stock No. 320119

Prescription No. ______

Name of drug ______

Purpose for taking this drug is ______

Prescription can be renewed ______ times

Take ______ every ______
(Amount) (How Often)

By ______ for ______
(Route or Method) (How Long)

Circle hours the drug is to be taken.

12
1
2
3
4
5
6
7
8
9
10
11
AM

12
1
2
3
4
5
6
7
8
9
10
11
PM

Physical description of the drug ______

______

This drug should __not__ be taken with ______

This drug should be taken with ______

Possible side effects ______

______

Contact your physician or pharmacist if the following side effects occur ______

______

Special instructions ______

______

______

Prescription No. ______

Name of drug ______

Purpose for taking this drug is ______

Prescription can be renewed ______ times

Take ______ every ______
(Amount) (How Often)

By ______ for ______
(Route or Method) (How Long)

Circle hours the drug is to be taken.

12
1
2
3
4
5
6
7
8
9
10
11
AM

12
1
2
3
4
5
6
7
8
9
10
11
PM

Physical description of the drug ______

______

401

This drug should __not__ be taken with ______

This drug should be taken with ______

Possible side effects ______

______

Contact your physician or pharmacist if the following side effects occur ______

______

Special instructions ______

______

______

UNIT G: REHABILITATION

ESTIMATED TIME: 2 hours

SUGGESTED INSTRUCTOR: Rehabilitation Nurse, Physical Therapist

INTRODUCTION

This unit covers the skills used to help the person maintain and improve physical strength and energy and help the disabled to better perform the activities of daily living. Included are suggestions for the use of devices and special consideration for helping the person move more easily with one-sided weakness.

In addition, range of motion exercises are explained for both passive and active exercise.

EXPECTED OUTCOMES

The trainee will be able to:

- assist the person with range of motion exercises
- assist the disabled person with ways to perform the activities of daily living.

SUGGESTED MATERIALS/EQUIPMENT

Samples of some utensils that have been modified for use by a disabled person, and crutches and walkers.

CONTENT

Part 1: Needs of the Person with Limited Function

Exercise 1, Rehabilitation and Meeting Human Needs, may be used as a basis for this discussion.

Many people with physical limitations find that developing even a small degree of independence is a very slow and difficult task. It is important for the person who has limited function to be encouraged to find easier ways to do as much for himself as possible. The person who has to depend on others for help may feel a lack of control of his life. Help is needed to accept the limitations that cannot be changed. The homemaker-home health aide will need to be patient and encouraging. The person will need time to complete even the most simple tasks of daily living. The elderly person needs more time to complete activities when well. Therefore, more time and patience will be required for the elderly person's recovery and rehabilitation. Exercises are also used to prevent disabilities from occurring, especially for persons confined for long periods of time.

The whole process of rehabilitation requires loving concern for the person, a positive attitude, and an understanding of the depression and negative attitudes expressed at times by the person who is struggling to rebuild his life. It is often not easy and requires a mature attitude on the part of the helping person.

Part 2: Range of Motion Exercises

It is important to explain carefully and clearly what will be done, step by step. Explanations and demonstrations may need to be repeated often.

Range of motion exercises should be demonstrated. It should be emphasized that in actual field practice any range of motion or treatment exercise should be demonstrated by the nurse or physical therapist for each individual receiving care.

Every joint has a specific direction through which it moves. Moving or having parts of the body moved through these normal motions is called "range of motion". The main purpose of these exercises is to keep the joints flexible. These exercises should be started early in the illness but only when ordered.

In Unit E the advantages of increased activity were discussed. Many of these points also apply to the purposes of doing range of motion exercises:

- prevent or decrease contractures and joint deformity caused by stiffness

- prevent muscle weakness and improve muscle tone

- increase circulation

Two different types of exercise can be done: passive—the person relaxes while the joint is moved through its full range; active—the person does the exercises himself. The plan of care will indicate whether passive or active exercises are to be done.

To do the exercises:

- explain what will be done.

- repeat each exercise 2 to 5 times a session, once or twice a day (or as advised), exercising both sides of the body

- support body parts above and below the joint when moved

- make the movement as complete as possible in a slow, steady manner, but cause no pain; there may be slight discomfort initially, but this will improve as the muscles and joints become looser

- place the person close to the edge of the bed and in good alignment before beginning

- use good body mechanics while doing the exercises (see Section IV, Unit D)

Demonstrate each exercise with a volunteer doing the passive exercises. Have trainees pair off and demonstrate each exercise.

Neck exercises. These exercises should be done only with special orders by the physician. The supervisor will advise about which exercises are to be done and when to start them.

The following exercises may be passive or active. Preparation for a passive exercise is described first and then the motion, which may be either passive or active.

Shoulder exercises. Grasp the person's arm by placing one hand above.the elbow and with the other hand support the person's wrist and hand. Motion: move the arm

- forward and upward along the side of his head

- downward to his side

- sideways away from the body to above the head and back to the starting position

- with the upper arm resting on the bed and elbow bent, turn lower arm down and then up.

Elbow exercises. Grasp the person's arm by placing one hand above the elbow; then with the other hand support his wrist and hand. Motion:

- move the hand toward the shoulder

- straighten the arm.

Forearm exercise. Rest the person's upper arm on the bed with the forearm upright. For passive exercise, grasp his wrist with one hand and his hand with the other. Motion:

- twist the palm toward the person and then away.

Wrist exercise. Grasp the person's forearm and wrist with one hand, and use the fingers of the other hand to do the exercise. Motion:

- move the hand forward
- move it backward
- move it side to side.

Finger exercise. Support the person's forearm and wrist with one hand, and use the fingers of the other hand to do the movement. Motion:

- bend fingers, then straighten them
- spread fingers apart and bring them together.

Thumb exercise. Support the person's hand and fingers with one hand, and grasp his thumb with the other hand for the exercise. Motion:

- move the thumb across the palm and straighten
- move the thumb in a wide, circular motion.

Hip and leg exercise. Support the person's leg by giving support under his knee and heel. Motion:

- raise the knee toward the chest, within the person's tolerance and comfort
- raise the leg straight up and as high as possible, and lower the leg gently.

Because of the risk involved especially to elderly people and the very young, rotation of the hip would be done only on special order or direction and usually by the nurse.

Continue to support the leg by placing one hand under the ankle and the other hand just under the knee. Motion:

- move the leg outward from the body as far as possible
- return the leg to the starting position and move it across the other leg as far as possible.

Rest the person's leg on the bed. For passive exercise, place one hand on top of his knee and the other on top of his ankle; or, if the leg and hip are flexed, place on hand under his ankle and one under his knee. Motion:

- turn the leg inward (toes toward center) and then outward.

Have the person lie on his side or stomach and support the leg by placing one hand at the knee and the other at the ankle. Motion:

- move the entire leg back as far as possible.

Knee exercise. Support the person's leg by placing one hand just above his knee, and grasp his ankle with the other hand. Motion:

- bend the leg at the knee by sliding the heel as far up toward the buttocks as possible
- straighten the knee completely.

Ankle exercise. Rest the person's leg on the bed. For passive exercise, place one hand just above the ankle to stabilize it, and grasp the heel in the palm of the other hand, the sole of the foot resting against your forearm. Motion:

- move the foot up toward the leg
- move the foot down away from the leg
- turn the foot so the sole faces out away from the body
- turn the foot inward toward the body.

Toe exercise. Hold the person's foot with one hand, and use the other hand to do the motion:

- bend toes down toward the ball of his foot
- bend toes back.

Part 3: The Person with One-Sided Weakness (Stroke)

Demonstrate movement. Use a volunteer to show the motions required.

The person with a one-sided weakness may have loss of half of the visual field of one or both the eyes. He may also see the world as slanted. This is important to consider in moving and transferring the person. He also tends to fall on the weak side.

Moving the person in stages, such as sitting up, moving into the chair and walking, was demonstrated in Units D and E. Rehabilitating the person in steps enables him to master simpler tasks, gain strength and confidence and learn to work with his weak side.

The person with one-sided weakness should:

- begin rehabilitation as soon as possible, according to the care plan

- be evaluated by the care team so special services such as speech or physical therapy can be included as necessary.

When doing range of motion exercises the person should use his strong hand, arm and leg as much as possible, to guide the weaker side of his body. (Using the weak side should be encouraged.)

For example, interlock fingers of the strong hand with the weaker hand to help move the weak hand. Grasp the weaker limbs with the strong hand to do the range of motion exercises.

Teach the person to put the strong foot under the weak ankle when crossing the legs, to roll over or to move the foot and leg. He should roll onto his strong side first when changing positions.

When sitting, support the weak shoulder by putting the elbow on an armrest, or use a lapboard with pillows on it. When lying on his side, have the person's weak shoulder supported to bring it forward. The weak hip and knee should be bent to 90 degrees and the strong leg, hip, and knee slightly bent. Have both arms out straight, fingers interlocked with a pillow between the arms.

When on his back, have the weak arm straight out, away from the body and propped by a pillow. The palm should be up. Place a towel roll under the weak hip to keep it from rolling out. Bend the weak knee and hip with support under the knee. Do not allow the arm to rest in a bent position on his chest.

Part 4: Use of Crutches, Walkers and Canes

Demonstrate the use of crutches and canes. If possible, each trainee should practice using crutches and canes in order to get the feel of them.

Crutches should be fitted and used only on the doctor's orders. When used over a period of time, crutches may need to be refitted periodically. A physical therapist or rehabilitation nurse should instruct the person needing crutches, and the aide in their use.

Before the person can use crutches, he must:

- have strength in his shoulders, arms, and legs
- be able to move his legs forward
- be able to stand erect
- be able to wear sturdy shoes
- be psychologically motivated to walk
- have adequate balance.

Check rubber tips frequently to remove dirt and replace tips when worn.

Types of crutch:

- Axillary crutches: those that fit under the armpit. They may be made of wood or aluminum. Light-weight aluminum "Duralite" is often used for persons with arthritis. The weight of the body should never rest on the axilla.

- Telescopic or "Adjusto" crutches: these open to full length, elbow length, or can be used as a cane. The swivel hand-pieces move both up and down and sideways. These crutches are useful for persons with shoulder and elbow abnormalities.

- Nonaxillary crutches (Canadian or Lofstrand crutches): these crutches extend to halfway between the shoulder and elbow. There is a crosspiece to help support the upper arm of those persons who have weak arm muscles. A cuff that goes over the arm helps hold the crutch in place but limits arm motion somewhat. A period of training is needed to use this type of crutch.

For the person who is weak or has difficulty with balance, a walker gives support and stability.

With a rigid walker:

- place the walker in front of the person

- the person picks it up and moves it forward, leaning on it

- move one foot forward and then the other

- a bicycle basket can be fitted over the walker to carry items used by the person

- the person with one-sided paralysis should not use a walker, as he may tip it toward his affected side

- in transfer from the bed/chair or toilet stand up and then grasp the walker; to sit, release the walker, grasp the chair firmly, and lower self to the chair; never grasp the walker when getting up or down.

Canes help provide balance for the person unable to use a walker, the person with one-sided weakness, or the person who needs some additional support when walking. Canes may be forked, have a quad base or be the traditional straight cane.

- the cane should be held in the unaffected hand and should be long enough for the person to hold the handle when the elbow is slightly bent

- hold cane in the hand opposite the weak leg; place the rubber-tipped end 6 inches in front and 6 to 8 inches to one side of the foot

- both canes and crutches should have rubber caps on the bottom to prevent slipping; check these for dirt and replace as they become worn.

Part 5: Adapting the Environment

The next subject is discussion of devices to help the person who does not have full function. Ask the trainees to describe devices they know about. The instructor should have access to one or more publications that describe devices and adaptations for the disabled.

Adaptations of the environment and the proper devices can help the person with disabilities, low energy and the elderly function as independently as possible. Achieving even a small degree of independence may require a major effort by the individual. It requires simplification of the work to be done, help from the family, professionals and community resources. Occupational therapists and physical therapists are examples of professionals that can be helpful in adapting the environment and selecting the proper devices for the individual.

When possible, use ordinary household items which may help the person increase his ability to function. Many items can be improvised which will help the person acquire skills in carrying out daily activities.

In the kitchen area it helps to stabilize containers by mounting such items as holders for towels, foil and napkins on the wall. Stabilizing devices such as a vegetable peeler or other utensils on an aluminum spike attached to a board helps the person function with one hand. Lightweight bowls may be stabilized by putting them into a hole cut in a pull-out board in the built-ins. Grab bars may be added in the kitchen if the person has difficulty in standing. Railings may be attached to the wall to aid the person in walking in the kitchen area and throughout the house.

Cooking utensils and measuring spoons with flat bottoms are more stable for pouring ingredients. Perforated spoons or ladles make it easier for the person to lift food from hot liquid. Enlarging the handles makes eating utensils easier to hold. A sponge rubber hair curler taped over the handles is an example. Pan lids and other utensils may be easier to use by enlarging the knobs or lengthening the handles. Examples of other available devices are an egg separator, an opener for screw-on lids, a rocking knife or pizza cutter to cut food, and a wedge board (similar to a picture frame in which bread can be wedged for buttering).

The use of a plate guard or deep dish will make it easier to pick up the food. A straw will assist the person having trouble drinking. When sitting in the wheelchair, a board may be used for playing games, eating snacks, or writing.

Cooking units placed at waist height are easier to use and safer for a person in a wheelchair. Food and utensils should be stored to be readily available at waist height and arranged so that frequently used items are closer to the work area.

When a person is confined to a wheelchair, short-handled tools are easier to control. For example, a mop handle or broom can be shortened. A vacuum sweeper on runners or wheels can move along with the wheelchair.

Personal grooming. Clothing or undergarments, including brassieres, with Velcro openings, hooks, or snaps in front make it easier for the person with limited function to dress. It may be easier to dress in clothing one half to one size larger than normal. Pants, skirts, and dresses that slip easily over the hips should be worn. Loose sleeves make dressing easier. Have the person put his strong arm or leg into the garment first and undress by using the strong arm or leg first. Wear slip-on shoes rather than tie shoes.

Grooming aids may also be easier to use if handles are made longer, such as brushes or combs. In addition, a person with the use of one hand may find roll-on makeup and roll-on deodorant easier to use. The person with one-sided weakness with vision problems may want to put makeup on the unaffected side first to use as a guide for the affected side. Devices which slip onto several fingers or the first finger and thumb help hold items such as a pencil or brush so these items do not need to be grasped.

SELECTED REFERENCES

American Heart Association. "Do It Yourself Again - Self Help Devices for The Stroke Patient". New York, American Heart Association, 1969.

American Heart Association. "Strike Back at Stroke". Dallas: American Heart Association, 1976.

American Heart Association. "Up and Around, A Booklet To Aid the Stroke Patient in Activities of Daily Living". Dallas: American Heart Association, 1976.

American Red Cross. *Health in The Home*. Garden City, New York: Doubleday, Publication date pending.

DuGas, Beverly Witter, R.N., B.A., M.A., Ed.D., *Introduction To Patient Care*. 3rd ed. Philadelphia: W.B. Saunders Co., 1977.

Fowler, Roy S., Ph.D., and W.E. Fordyce, Ph.D., "Stroke: Why Do They Behave That Way?" Seattle: Washington State Heart Association, 1974.

Gilbert, Jeanne G., Ph.D. *The Paraprofessional and The Elderly*. Greenvale, New York: Panel Publishers, 1977.

Klinger, Judith, O.T.R., M.A., *Mealtime Manual for People with Disabilities and The Aging*. Prepared by the Institute of Rehabilitation Medicine, New York University Medical Center and Campbell Soup Company. Second Edition, 1978.

Long, Janet M., (ed). *Caring for and Caring About Elderly People: A Guide to the Rehabilitation Approach*. Philadelphia: J.B. Lippincott Company, 1972.

May, Elizabeth E., Neva R. Waggoner, and Eleanor Boettke Hotte. *Independent Living for the Handicapped and The Elderly*. Boston: Houghton Mifflin Company, 1974.

Schultz, Lucic, C.M. "Nursing Care of the Stroke Patient". *The Nursing Clinics of North America*. Vol. 8, No. 4. Philadelphia, W.B. Saunders Company, December, 1973.

Sine, Robert D., M.D., Shelly E. Liss, M.D., Robert E. Roush, Ed.D., J. David Holcomb, Ed.D. (eds). *Basic Rehabilitation Techniques*. Germantown, MD.: Aspen Systems Corporation, 1977.

Veterans Administration Department of Medicine and Surgery. *Basic Health Care Student's Study Guide*. Washington, D.C., Government Printing Office, 1974.

Wood, Lucille A., and Beverly J. Rambo. *Nursing Skills for Allied Health Services*. Vol. 1, Philadelphia: W.B. Saunders Company, 1977.

ASSESSMENT

Instructions: Circle the word true if you think that the statement is true and circle the word false if otherwise.

True False 1. The aide should allow the person to do as much for himself as possible even though he has limited functions.

True False 2. It is important to provide support of the body parts above and below the joints when it is moved.

True False 3. The person with one-sided weakness may have loss of half of the visual field of one or both eyes. He may also tend to fall toward the stronger side.

True False 4. Rehabilitation should be started as soon as possible.

True False 5. Rehabilitation involves concern for the person, an understanding of his attitudes and a sensitivity to his feelings.

True False 6. If the person cannot talk, explanations of things to be done for him can be omitted.

True False 7. All joints have a capability to move in all directions.

True False 8. When you are doing the exercise for the person it is called active exercise.

True False 9. The principle of good body mechanics should be observed by the homemaker-home health aide to prevent pain, strain or injury.

True False 10. Improvising devices if they are not available may be necessary. For example, many devices can be made useful by enlarging or lengthening their handles.

True False 11. To gain strength and confidence should be made the goal during the early part of rehabilitation.

True False 12. When doing range of motion exercises the weaker side of the body such as the hand and arm should initially be used to move the stronger hand and arm.

ANSWERS

1. True
2. True
3. False
4. True
5. True
6. False
7. False
8. False
9. True
10. True
11. True
12. False

AIDS

Exercise 1: Rehabilitation and Meeting Human Needs

Discussion Questions 1: Rehabilitation

Handout 1: Exercises

Exercise 1: Rehabilitation and Meeting Human Needs

This exercise will provide for a focused discussion of meeting human needs of individuals and families for selected rehabilitation situations.

- Ask the trainees to list several types of rehabilitation situations that may be encountered.
- List basic human needs that would apply in all the situations.
- For each enumerate the special needs of the persons served and specific knowledge or skills needed.
- Have the group indicate how each of those needs will be met.
- Discuss the role of the homemaker-home health aide.

Discussion Questions 1: Rehabilitation

1. Why are range of motion exercises important?
2. What changes can be made on many ordinary household items to help the handicapped person function better?
3. What things can make eating easier for the disabled person?
4. What attitude is important in working with a handicapped person?
5. What are some of the important points to consider when caring for a person with one-sided weakness?

Handout 1: Exercises

SHOULDER EXERCISES

Grasp the person's arm by placing one hand just above the elbow and with the other hand support the person's wrist and hand, (or have the person) move his arm:

- forward and upward along the side of his head;
- downward to his side;
- backward from the starting position;
- sideways away from the body to above the head and back to the starting position;
- outward from the shoulder with the upper arm resting on the bed and elbow bent, turn lower arm down and then up.

ELBOW EXERCISE

Grasp the person's arm by placing one hand above the elbow and with the other hand support his wrist and hand (or have the person):

- move the hand toward the shoulder;
- straighten the arm.

FOREARM EXERCISE

Rest the person's upper arm on the bed with the forearm upright. Grasp his wrist with one hand and his hand with the other, (or have the person):

- twist the palm toward the person and then away.

WRIST EXERCISE

Grasp the person's forearm and wrist with one hand and use the fingers of the other hand to (or have the person):

- move the hand forward;
- move it backward;
- move it side to side.

FINGER EXERCISE

Support the person's forearm and wrist with one hand and use the fingers of the other hand to (or have the person):

- bend fingers, then straigten them;
- spread fingers apart and bring them together.

THUMB EXERCISE

Support the person's hand and fingers with one hand and grasp his thumb with the other hand (or have the person):

- move the thumb across the palm and straighten;
- move the thumb in a wide, circular motion.

HIP AND LEG EXERCISE

Support the person's leg by giving support under the knee and heel (or have the person):

- raise the knee toward the chest producing as much bending at the hip as possible, within the person's tolerance and comfort;
- raise the leg straight up as possible, hold for a count of five (5) and lower the leg gently.

Continue to support the leg by placing one hand under his ankle and the other hand just under the knee (or have the person):

- move the leg outward from the body as far as possible;
- return the leg to the starting position and move it across the other leg as far as possible.

Rest the person's leg on the bed, place one hand on top of his knee and the other on top of his ankle - or if the leg and hip are flexed place one hand under ankle and one under his knee (or have the person):

- turn the leg inward (toe toward center) and then outward;
- have the person turn on his side or stomach;
- move the entire leg back as far as possible.

KNEE EXERCISE

Flex the person's hip; raise the leg high and support his leg by placing one hand just above his knee and grasp his ankle with the other hand (or have the person):

- bend the leg at the knee;
- straighten the leg.

ANKLE EXERCISES

Rest the person's leg on the bed. Place one hand just above the ankle to stabilize it and grasp the heel in the palm of the other hand. The sole of the foot should be resting against the forearm (or have the person):

- move the foot up toward the leg:
- move the foot down;
- turn the foot so the sole faces out away from the body;
- turn the foot inward toward the body.

TOE EXERCISES

Hold the person's foot with one hand and use the other hand (or have the person):

- bend toes down toward the ball of his foot;
- bend his toes back.

UNIT H: SIMPLE TREATMENTS AND EMERGENCY CARE

ESTIMATED TIME: 3 hours

SUGGESTED INSTRUCTOR: Professional nurse or first-aid instructor for emergency care

INTRODUCTION

This unit describes how the homemaker-home health aide applies moist and dry hot and cold treatments, takes weights, applies nonsterile dressings, and gives simple emergency care.

EXPECTED OUTCOMES

The trainee will be able to:

- apply both moist and dry hot and cold treatments
- apply nonsterile dressings
- weigh a person
- give simple emergency care.

SUGGESTED MATERIALS/EQUIPMENT

See each section of the unit.

CONTENT

Demonstrate the application of unsterile dressings. Write on the board the equipment: a paper or bag for disposal of the soiled dressing, clean dressing, tape, and tongs or spring clothespin to pick up the soiled dressing.

Part 1: Dressings and Simple Treatments

Dressings which are not sterile may require changing, but should only be done when and as indicated in the care plan. Dressings put over wounds or surgical openings are usually sterile. However, a dry nonsterile dressing may also be used over the skin when the skin is not broken or the wound is healing and well crusted over.

To change an unsterile dry dressing:

- the homemaker-home health aide should wash her hands
- explain to the person what will be done
- assemble equipment
- keep the dressing clean and as free from contamination as possible, even though it is not a sterile dressing and will not be in contact with an open sore or break in the skin
- remove the tape and soiled unsterile dressing, picking it up with a spring clothespin or tongs or by touching only the cleanest part
- wrap the soiled dressing in several layers of paper or a paper bag, to be discarded in the incinerator or covered trash container
- observe the sterile dressing that is being removed for any discharge
- apply and tape the unsterile dressing in place
- wash hands
- record observations of the dressing on the care plan and the time when the dressing was changed
- report anything unusual to the supervisor, such as pus, hot, reddened area around the wound, foul odor, excessive drainage or bleeding on the dressing.

The next skills to demonstrate are how to apply hot and cold treatments. Hot or cold treatments should never be done without orders. The care plan will include what treatments are to be done by the homemaker-home health aide.

Hot Applications

The purposes for the use of heat are to:

- warm the person
- ease aching muscles
- increase circulation
- promote healing
- promote comfort.

The instructor may use or modify Exercise 1. Write equipment needed on the board: hot water bag, stopper, pitcher, water, cloth cover, thermometer (optional).

To apply a hot water bag: The homemaker-home health aide should apply heat only if specified in the treatment plan or by the supervisor. Sometimes heat might be the wrong kind of treatment and cause injury. Heat may be either dry or moist. Common forms of dry heat are the hot water bottle and the electric heating pad.

When applying a hot water bottle, the water should be tested with a cooking thermometer or the clenched fist: that is, hot enough for the fist to stand it for a moment or the thermometer to register a temperature of 115° to 130° F (45° to 54.4° C). The bag should be filled 1/3 to 1/2 full. Remove air by laying it flat on the table. Be sure there are no leaks, and cover with a soft cloth before applying to the area of the body. Refill when bottle becomes cool.

Check the area for redness. If area becomes red or painful, call the supervisor. Extra care must be used in applying heat to children and older people because of greater sensitivity to heat. Record when and for how long the hot water bottle was in place.

After use remove the stopper, empty, and turn the bag upside down to drain. After it is dry, allow some air into the bag to prevent sticking.

Demonstrate application of a hot compress.

Hot compresses are forms of moist heat that are sometimes used instead of dry heat because they are more effective in certain treatments such as infections and are more easily applied to certain areas of the body such as the eyes. Several methods may be used. Material (lightweight wool is good) should be cut 2 to 4 times larger than the area to be treated and be 4 thicknesses. Moisten with warm water, and wring it as dry as possible. Cover with a cloth and plastic. On some parts of the body a binder may be used to hold the compress in place and a safety pin to hold the binder in place. Avoid pressure. A heating pad that is rubber-protected or a hot water bottle may be applied to keep the compresses hot. Apply the heating pad to the person, but do not have the person lie on it. Lying on the pad retains the heat and may cause a burn. Follow the instructions of the Underwriters Laboratory which accompany the pad. Keep the hot compress in place for the prescribed length of time. A simple method is to use a washcloth wrung out of hot water; cover with plastic and a hot water bottle to maintain the heat.

Report any unusual redness or pain to the supervisor and record when the treatment was started, discontinued, and the individual's reaction to it.

Demonstrate the use of cold treatments. Write on the board equipment to be used: ice bag, collar, or heavy plastic bag such as a freezer bag, crushed ice, soft cloth cover, safety pins. Refer to Exercise 1.

Cold Applications

Cold applications are used to reduce swelling, pain, and to stop bleeding. Cold applications may be either dry or moist. The homemaker-home health aide will apply cold only when indicated on the plan of care. Improperly applied, an ice bag can cause damage, especially in an area of poor circulation. The area should be observed for any unusual changes in the skin color, such as pallor.

Procedure:

- crush ice and place in the container, filling it 1/3 to 1/2 full, and remove the excess air by forcing it out of the bag with the hand or laying it flat on a surface
- wrap and pin the cloth cover over the container before placing it on the area to be treated
- add ice as the bag warms, and change the outside cover when it becomes moist
- continue the treatment for the length of time ordered by the physician
- record on the care plan the time the treatment was started, the reaction and if there were any unusual signs or symptoms and, if so, contact the supervisor
- prepare the container for storage as was done with the hot water bottle.

Use of cold moist compresses is the next treatment to be discussed. Write on the board the equipment needed: two or more compresses, ice water, plastic, towel.

Moist cold compresses are used in certain treatments when ordered by the physician.

Procedure:

- place a towel under the area to be treated
- moisten the compress in ice water; wring it out and place it on the area to be treated
- cover with pastic if desired, to retain cold longer
- change the compress as soon as it warms

- continue the treatment as long as ordered

- usually the treatment is not effective after 15 to 20 minutes.

Weighing a Person

The person should be weighed when it has been ordered. Observe first if the person appears to have good balance and feels strong enough to stand on the scales.

A person's loss or gain of weight can be a very important indication of the person's state of health and response to treatment. If the person has a heart condition with fluid retention and edema and is taking drugs, weighing the person indicates progress in reducing the fluid retention and effectiveness of the drug. Obtaining an accurate weight is, therefore, important.

Procedure:

- explain what will be done

- bring the scales to the bedside

- if needed, adjust the scale so the pointer is at zero

- have the person remove his shoes and robe

- have the person step on the scales, being ready to assist him if he becomes unsteady

- observe the weight; do not hold onto the person at this point (unless he is falling), as extra pressure on him will add to his weight

- if necessary, help him off the scales and back to bed or to a chair

- record on the care plan his weight, when he was weighed, and how he tolerated the procedure.

Ostomy Care

The care of the ostomy will be done by the professional. In some instances it may be necessary to clean the surrounding area and give care to the skin. It is important that the homemaker-home health aide know what an ostomy is and general care such as diet and the support needed by the individual.

An ostomy is a surgical opening into the intestine through the abdominal wall. The opening may be on the right or left side of the abdomen and is called a stoma. The waste matter from the bowel discharges through this opening, which takes the place of the anus. One can live comfortably with part or all of the large intestine removed, since it functions primarily to absorb water and store waste material.

Surgery which removes part of the large intestine (colon) is called a colostomy. Surgery removing all of the colon and leaving the small intestine is called an ileostomy. The removal of the urinary bladder is another operation that makes an opening in the abdominal wall, which is called a urinary bypass or ureterostomy.

The care of the ostomy depends on where the surgery occurs; the farther down the colon it is, the more closely the bowel contents will resemble the normal bowel movements before surgery; the higher up the bowel, the more liquid the bowel contents will be.

The person with an ostomy is usually taught to care for it before he goes home from the hospital. If more care is needed, the nurse will provide it.

Persons who have had any of the surgical procedures creating an ostomy will be using a bag or device for collecting body waste. There are various types of ostomy bags. The individual will use the type of bag best suited to his needs and life style. The types of bag include:

- a disposable, temporary bag with an end opening to discard contents
- a one-piece bag with an attached piece of adhesive around the opening of the stoma
- a one-piece bag with attached mounting piece which is supported by a lightweight belt and requires no adhesive.

The homemaker-home health aide may be asked to help the person clean the skin or to dispose of the contents of the bag. Some points to remember are:

- bags with an end opening can be rinsed out with an asepto syringe as needed and do not need to be changed as often, which reduces skin irritation
- the person will want two bags so one can air out while the other is worn
- some people with colostomies who have good bowel regulation prefer to wear only a gauze dressing over the stoma
    - . clean and dry skin around the stoma and cover it with a 4" x 4" dressing held in place by tape
    - . use care not to spread germs when changing the dressing; put the soiled dressing into newspaper and dispose of it in the trash
    - . men may wear an elastic supporter or a homemade muslin binder with ties to keep the dressing in place

- the ileostomy bag requires a tight fit because of the liquid bowel contents and constant drainage; the appliance or bag must be changed when there is leakage; it may need to be emptied every 3 to 4 hours and changed every 5 to 7 days.

The diet needs careful consideration. Foods, particularly those that are gas-forming, will have to be experimented with. Common foods that cause gas for many people are: nuts, beans, onion, melons, vegetables of the cabbage family, sugar and sweets. Gas escaping from the ostomy cannot be controlled, since there are no muscles present to close the opening. The tight-fitting rubber or plastic bag helps control odors, but the dressing gives no protection against odors. Foods such as nuts, raisins or prunes which cause diarrhea should be avoided. Prevention of diarrhea is even more important for the person with an ileostomy because of the loss of important electrolytes. A person with an ileostomy should never eat coconut, as it tends to "ball up" and could cause an obstruction. Remind the person to chew food well. After approximately six weeks the person will be able to better determine the foods he can tolerate.

Notify the supervisor if the person has diarrhea. The person should not irrigate the ostomy when diarrhea is present. The person who has a colostomy should never take a laxative.

The emotional reactions to the loss of bowel control require a great deal of support and understanding. It is important to be a good listener. Another person who has successfully adjusted to his colostomy often provides great assistance in demonstrating how well one can manage. Local contacts may be made through the American Cancer Society or the United Ostomy Association. Part of the grief process felt by the person over loss of a body part might have occurred before leaving the hospital. It is important to help him express his emotions, as he still may not accept the surgery and be repulsed by the stoma. Try to help him feel as calm as possible. Help him understand that adverse emotions affect the bowel motion and the regulation of the bowel. The homemaker-home health aide must be very careful to show no distasteful reaction to the stoma. The person needs to feel accepted by those around him, particularly those giving him care.

Part 2: Emergencies

This part of the unit deals with emergency situations and the care which should be given.[1]

First aid is care needed for persons who suffer accidents or sudden illnesses. A person should be treated as a whole entity--physically, emotionally, and mentally. The person may need reassurance as well as physical care. The whole environment must be evaluated, as care may be needed to prevent further injury. First aid also includes care that must be given if help is not available or is delayed.

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[1] American Red Cross. Advanced First Aid and Emergency Care, 2nd ed., 1979.

Since this section covers only the most life-threatening situations, it is advisable to take a course in cardiopulmonary resuscitation and have a current American Red Cross or other first aid book readily available in the home for information about care of other emergencies that are less life-threatening.

In the home, emergency phone numbers should be posted by the phone. These should include emergency squad, fire department, physician, hospital, police department, and poison-control center. If someone needs immediate help, it may be up to the homemaker-home health aide to evaluate the situation and give emergency care according to the priority of needs. *See Exhibit 1.*

Emergency care includes:

- help to restore breathing
- help for the heart attack victim
- stopping heavy bleeding
- care for poisoning
- care for shock.

Do not leave someone who needs immediate help. Have someone else call for help. When someone needs help but not immediate care to sustain life, the homemaker-home health aide's responsibility is to prevent more injury, seek medical help, and keep the person calm. Good judgment is needed to give good emergency care. The whole situation must be looked at, to see what help is needed first and what the problems are.

Refer to Exhibit 2 for steps to take.

The eight steps to be taken in order of action are:

- rescue the person if there is danger to the person
- restore or maintain breathing and heartbeat
- control heavy bleeding
- treat poisoning or ingestion of harmful chemicals
- prevent or reduce shock
- examine the person carefully
- seek medical help
- keep checking the person until medical help is obtained; let the supervisor know what has happened as soon as it is safe to leave the person unattended.

One of the first decisions is whether or not the person should be moved. Do not move the person unless you must. Consider the injury that moving might cause the person, the danger to the rescuer or person from surroundings and the danger to the person from existing injuries and other conditions. Examine the person methodically. Loosen constricting clothing and remove or open clothing as needed to examine the person adequately.

Maintaining and Restoring Breathing

The first priority for emergency care is to restore and maintain breathing. This is called mouth-to-mouth resuscitation. Have students return the demonstration.

Check first for breathing. To tilt the head, place one hand under the neck, lift gently, and push down on the forehead with the other hand to open the airway and check for breathing. Put your cheek and ear close to the victim's mouth. Listen and feel for the breath for about 5 seconds. If the person is not breathing, remove any obvious material in the mouth or give mouth-to-mouth breathing right away:

- send someone to call for help
- keep the head tipped back, and pinch the nose with the thumb and fore inger of the hand on the forehead; take a deep breath and open your mouth wide
- cover the person's mouth with your mouth, and blow four quick, full breaths, as fast as possible, but lift your head and take a breath between each four breaths
- after four breaths check his pulse and his breathing again for at least 5 but no more than 10 seconds (check the pulse on the side of his neck nearest you by placing the fingers on the far side of the voice box, mid-neck
- if the person has a pulse and is not breathing, give one full breath every 5 seconds
- for a baby, blow into the mouth and nose and give small puffs of breath every 3 seconds
- if there is no pulse, cardiopulmonary resuscitation is needed; if the homemaker-home health aide has not been trained to give CPR, continue mouth-to-mouth breathing until help arrives; there may be a faint pulse which is not felt.

Control of Bleeding

Have students practice applying pressure over the "wound".

If the person is bleeding heavily, the best way to control it is to hold a thick pad of clean cloth over the wound and to press down hard. If no pad is available, use the bare hand until one can be obtained. If the injury is on an extremity, and if there are no broken bones, also raise the injured part above the level of the heart. Support it with rolled-up coats, etc. Maintain these measures until help arrives.

Foreign Body in the Airway

First aid for foreign-body obstruction in the airway is another emergency action. (This information is from American Red Cross, First Aid for Foreign Body Obstruction of the Airway, 1978.)

Do not interfere with the person's attempts to expel an object if he is still able to breathe or cough. When there is complete obstruction:

- the person has probably been eating and may clutch the throat
- the person will be unable to speak, cough, or breathe
- his face may turn darker; if so, immediately:
  - . stand to the side and slightly behind the victim
  - . place one hand high on the hard part of the victim's chest, and lean the person forward until his head is chest-level or lower
  - . give 4 back blows in rapid succession
  - . give 4 manual thrusts
  - . repeat the above procedure until he can breathe.

Back blows are a rapid series of sharp whacks delivered by the heel of the hand over the spine and between the shoulder blades. These can be done with the person sitting, standing or lying.

To do a manual thrust:

- . stand behind the person who is now bent over, and place the thumb side of your fist, palm down, into the area just above the victim's navel
- . grasp the fist with the other hand
- . press the fist into the victim's abdomen with a quick upward thrust; do this 4 times.

- continue with the sequence of 4 back blows and 4 manual thrusts.

If the victim is unconscious:

- do mouth-to-mouth breathing if air can pass through; if there is no pulse, do cardiopulmonary resuscitation, if trained to do it
- remove any obvious foreign material in the mouth.

Demonstrate without a victim how to stand and wrap arms around his waist, for the manual thrust. Have students practice the position on each other without actually doing the thrust.

Emergency Care for Poisoning

Poisoning may be the cause of sudden collapse. Vomiting and heavy, labored breathing may mean the person has taken poison. These signs may also indicate disease, internal injury, or other problems. Look for a container which may help determine what the person has drunk or eaten. Check the mouth for chemical burns, and check to see if the breath smells. If the person is conscious and not having convulsions, give sips of water or milk to an adult and a little less to a child. This will dilute the poison. If the person becomes nauseated, discontinue the dilution. Try to identify the poison, and call the poison control center, emergency department or physician immediately. The printed antidote on the container may be wrong, so do not follow the directions. Keep syrup of ipecac, activated charcoal, and epsom salts on hand, as the poison control center may advise use of one of these. Also check to see if the person is breathing and prepare to give care for shock.

Care for Shock

Have students practice giving care for a "shock victim".

Take measures to prevent shock after first examination of the person is done and immediate care is given. Shock can happen to anyone who has lost a lot of body fluid, becomes extremely ill, or is badly hurt. Shock can keep the organs from working normally. It can be made worse by extreme fright or pain. A person can go into shock and die. Anyone with a serious injury should receive follow-up medical care—even if he appears to have recovered.

In the meantime care for shock should be given and will include the following:

- have the person lie down
- keep him as calm as possible
- keep him as comfortable as possible
- maintain a normal body temperature (if it is hot, provide shade; if it is cold, provide protection from cold both under and over the victim)

- elevate the feet, unless a broken bone or an abdominal or head injury is suspected; never elevate any unsplinted fracture.

If the person has a head wound or trouble breathing, elevate the head and shoulders only. The person should be flat on his back if a broken back is suspected.

When a person is bleeding from the mouth or vomiting, turn him on his side so fluid will drain from his mouth, if the injuries permit.

Burns

Burns are another household emergency that need first-aid treatment when they occur. (This information is from Red Cross First Aid Module - First Aid for Burns, 1977.)

The immediate hazards of burns are:

- shock

- swelling of tissues and breathing passages

- loss of body fluid through the burned area

- pain

- death.

Infection is always a danger, especially if there are blisters or loss of skin. The seriousness of a burn depends on the depth of a burn, the size, location, the size and physical condition of the person. Infants, small children, elderly persons, and persons who are weak or ill are at greater risk from burns than a healthy, younger person.

Four critical areas of the body are:

- hands

- feet

- face

- genitals.

Burns on the face, nose, and mouth may indicate burns in the respiratory system. This kind of burn may cause the passage to swell and interfere with the ability to breathe or stop breathing. If this occurs, give mouth-to-mouth respiration or CPR if necessary, and get immediate medical help.

A first-degree burn involves the top layer of skin. A second-degree burn involves more than the surface layers of skin. A second-degree burn and deeper on critical areas requires immediate medical attention. A third-degree burn goes entirely through the skin and may burn the tissue below. Any third-degree burn requires medical attention.

The purposes of first-aid treatment are to:

- relieve pain
- reduce the chance of infection
- reduce the likelihood of shock.

Cool water can be used directly on a small burn that is not open and not very deep. Cool the area until the pain is reduced. Pat dry, gently with sterile gauze. (Material may be sterilized by washing with soap and hot water and ironing several times with a hot iron.) If the burn is over a large area but not deep, cool as above, but cover with a sterile dressing. Dry, insulated cold packs may then be used over the dressing.

Do not put water on deep burns, because the skin and tissue are open and there is danger of infection:

- cover with a thick, dry, sterile dressing and bandage
- do not remove clothing stuck to a burned area
- dry, insulated cold packs may be used over the bandage
- have the person lie down and elevate the injured area if it does not cause more pain
- get medical care as quickly as possible.

Suspected Heart Attack

Heart attack usually occurs when one of the blood vessels supplying the heart becomes blocked. The person will usually experience pain and shortness of breath. The pain is in the chest and often radiates to the left shoulder, neck, or arm. The person may be very pale or have a bluish discoloration of the lips, skin and fingernail beds. As a rule, the person is in shock. The heart attack may or may not be accompanied by loss of consciousness.

It is imperative to take immediate action when intense pressure, tightness or squeezing in the center of the chest persists for five minutes or more, when it spreads across the chest or to either shoulder or arm, neck, or jaw, and when it is associated with sweating, nausea, vomiting, shortness of breath or fainting.

- place the person having a heart attack in a comfortable position; often a sitting position is most comfortable

- if breathing stops, immediately begin mouth-to-mouth resuscitation

- have someone call the ambulance or rescue squad equipped with oxygen and have the person's physician notified

- do not give liquids to an unconscious patient

- if the heart stops beating, "cardiopulmonary resuscitation", CPR (heart-lung revival), must be done by someone who has had training in this technique; most rescue squad and ambulance workers have had this training; the American Red Cross and American Heart Association offer CPR training through local chapters.

Convulsions (Seizures)

The homemaker-home health aide may encounter convulsions in ill or disabled persons and children. Understanding of the cause and immediate care are important to avoid panicking.

Convulsions (also called seizures) are involuntary and usually violent muscular spasms involving the entire body. During a convulsion the person is unconscious. In infants and young children convulsions may accompany a period of high fever. Convulsions that develop later in the course of a childhood disease are more serious and may indicate complications of the central nervous system. Convulsions which occur in older children and adults may accompany severe illness or a head injury or may be a form of epilepsy.

At the start of a convulsion the body muscles will be rigid for a few seconds. This phase is then followed by jerking movements and a bluish color of the face and lips. Drooling or foaming at the mouth may occur. Following a seizure the person will be very tired and sleep deeply.

First aid involves maintaining an open airway and preventing the person from hurting himself. Do not restrain him or try to stop his movements. Do not give any liquids; do not place him in a tub of water. Do not try to force anything between his teeth. Keep hands away from his mouth. Give mouth-to-mouth resuscitation if necessary. If repeated convulsions occur, consult the health professional, and take the patient to the hospital. Report the length and characteristics of the convulsion to the health professional.

SELECTED REFERENCES

American Red Cross. First Aid Module: Emergency Action Principles. Washington, D.C.: The American National Red Cross, 1977.

American Red Cross. First Aid Module: First Aid for Burns. Washington, D.C.: The American National Red Cross, 1977.

American Red Cross. First Aid Module: First Aid for Wounds. Washington, D.C.: The American National Red Cross, 1977.

American Red Cross. Family Health and Home Nursing Textbook. Garden City, New York: Doubleday, publication date pending.

American Red Cross. Home Nursing Instructors Guide. Washington, D.C.: American Red Cross, publication date pending.

Gibbs, Gertrude E., and Marilyn White. "Stomal Care." American Journal of Nursing. Vol. 72, No. 2, Feb., 1972, pages 268-271.

Gilligan, Thomas J., and V. Clayton Sherman. Health Aide Education and Utilization: A Task Identification Study. Kalamazoo: Homemakers Home and Health Care Services, Inc. Upjohn Co., 1974.

Wood, Lucile A., and Beverly J. Rambo. Nursing Skills for Allied Health Services. Vol. 2. Philadelphia: W.B. Saunders Co., 1977.

Visual Aids

People with Colostomies. 16mm color film. American Cancer Society #C 7063. Deals with attitudes.

ASSESSMENT

Please select the best answer by checking on the appropriate blanks.

1. The purposes for the use of heat are:

   a. to increase circulation

   b. to prevent bleeding

   c. to relax aching muscles

   d. to promote comfort

   ________ a, c, and d are correct

   ________ a, b, and c are correct

   ________ all are correct

2. Cold applications are used for the following purposes:

   a. promote healing

   b. stop bleeding

   c. reduce swelling

   d. ease pain

   ________ a, c and d are correct

   ________ b and d are correct

   ________ b, c and d are correct

   ________ all are correct

3. Observation of unusual signs is important when applying hot or cold compresses. The homemaker-home health aide should record on the care plan the following:

   a. any reaction to the treatment

   b. numbness when cold compress is applied

   c. redness or bluish color of the skin

   d. pain on the part

   ________ a and c are correct

   ________ b and d are correct

4. When surgery is done to remove a part of the colon it is called:

________ a. an ileostomy

________ b. a colostomy

________ c. urinary bypass

5. The purposes for giving emergency care to a person are:

a. to restore breathing

b. to provide nourishment

c. to sustain life

d. to control bleeding

________ a, c, and d are correct

________ a and d are correct

________ b and c are correct

________ all are correct

6 to 9. Among the many lifesaving activities rank the following in the order of what should be done first (mark 1-4).

6. ________ seek medical help

7. ________ rescue the person if there is danger to the person

8. ________ keep checking the person until medical help is obtained

9. ________ control heavy bleeding

10. Which of the following activities is the most applicable emergency measure to control heavy bleeding?

________ a. raise the injured part below the heart

________ b. place a thick pad of clean cloth over the wound and apply pressure

________ c. call the doctor

11. In case of poison, the following should be called first for help:

_________ a. the father of the person

_________ b. poison control center

_________ c. a taxi cab

12. Shock may be caused most likely by one of the following:

_________ a. severe bleeding

_________ b. hairline fracture

_________ c. thirst

13. In burns, which of the following could pose as an immediate threat to life?

_________ a. a loss of body fluid through the burned area

_________ b. pain

_________ c. shock

14. In burns, the critical areas of the body are:

_________ a. abdomen, hands and face

_________ b. genitals, hands, feet and face

_________ c. buttocks, abdomen, and chest

_________ d. none of the above

15. Symptoms of heart attack include:

a. pain in the chest

b. nausea and vomiting

c. bluish color of the lips

d. difficulty of breathing

_________ a, c, and d are correct

_________ a, b, and d are correct

_________ all are correct

16. When the person is unconscious, the most important thing to remember is:

________ a. provide warmth

________ b. do not give liquids by mouth

________ c. wake the patient up

17. To prevent poisoning of children, which of the following preventions is best:

________ a. keep poisons locked or in places where children cannot reach them

________ b. keep an antidote ready in case children take poison

________ c. have an emergency number to call

18. When a person needs help other than to sustain his life, your goals of care are to:

a. comfort the person

b. seek medical help

c. prevent more injury

________ b only

________ c only

________ all of the above

19. Which of the following should be given to a person with an ileostomy?

a. a laxative every night

b. gas-forming foods

c. nuts, raisins, prunes

________ all of the above

________ none of the above

________ a only

20. An unsterile dressing is used:

    a. to absorb drainage

    b. help keep the sterile dressing in place

    c. to hide an unsightly wound

    ________ all of the above

    ________ none of the above

    ________ a and b

ANSWERS

1. a, c, and d
2. b, c, and d
3. all are correct
4. b
5. a, c, and d
6. 3
7. 1
8. 4
9. 2
10. b
11. b
12. a
13. c
14. b
15. all are correct
16. b
17. a
18. all of the above
19. none of the above
20. a and b

AIDS

Exercise 1: Use of Hot and Cold Treatments

Exhibit 1: Emergency Care

Exhibit 2: Eight Steps in Emergency Action

Discussion Questions 1: Simple Treatment and Emergency Care

Exercise 1: Use of Hot and Cold Treatments

This exercise is designed to familiarize trainees with the following procedures. Preparation, administration, and follow-up will be covered.

- Divide into twos or threes.
- Describe each procedure or demonstration in use of hot and cold treatments.
- Alternate tasks within the small groups.
- Discuss benefits and limitations of each procedure. The role of the homemaker-home health aide should also be explored.
- Practice explaining the procedures and discuss how persons receiving the services might feel about them.

Exhibit 1: Emergency Care

- Help to Restore Breathing
- Help for the Heart Attack Victim
- Stopping Heavy Bleeding
- Care for Poisoning
- Care for Shock

Exhibit 2: Eight Steps in Emergency Action

Eight Steps to be Taken in Order of Action

Rescue the person if there is danger to the person.

Restore or maintain breathing and heart beat.

Control heavy bleeding.

Treat poisoning.

Prevent shock.

Examine the person carefully.

Seek medical help.

Keep checking the person until medical help is obtained.

Discussion Questions 1: Simple Treatment and Emergency Care

1. What are the reasons dry heat is used as a treatment?
2. Why is moist heat used as a treatment?
3. Why are cold treatments used?
4. In order of priority, name the first four emergency conditions that should be considered for action.
5. Why are unsterile dressings used?
6. Why is it important to weigh a person accurately?

UNIT I: MOTHER AND BABY CARE

ESTIMATED TIME: 1 hour

SUGGESTED INSTRUCTOR: Professional Nurse

INTRODUCTION

This unit describes basic care of the mother and infant. Included in this unit are demonstrations of how to hold, bathe, and feed the infant.

EXPECTED OUTCOMES

The trainee will be able to:

- apply important concepts of personal care during pregnancy and following birth of the baby
- aid the family in adjustment of the family to the new member
- bathe the baby
- hold the baby in a safe manner
- feed the baby.

SUGGESTED MATERIALS/EQUIPMENT

Audiovisual aids—Ross Laboratories; Maternity Center Association

a

Infant-sized doll

Bathtub (small plastic)

Lotion or powder

Diaper and shirt

Blanket

Towel and washcloth

Soap and soap dish.

CONTENT

Part 1: Caring for the Mother

This unit deals with some of the important concepts of personal care during pregnancy and after the birth of the baby.

Pregnancy is, by and large, a normal process. Seldom do complications occur, but when they do, they can be serious. It is, therefore, important for the mother-to-be to seek medical care as soon as she suspects she is pregnant. Homemaker-home health aide services for a pregnant mother usually occur if it is a complicated pregnancy or the mother is under unusual stress because of family responsibilities and there are several other children.

When in the home setting and taking care of a pregnant woman, the important things for the homemaker-home health aide to remember are:

- encourage a balanced diet; this is important for the mother and especially for the growth of the fetus
- follow the care plan carefully, which will include activity orders; bed rest is sometimes ordered for high blood pressure or vaginal bleeding which may occur, with a threat of miscarriage
- make sure the physician is aware of any medication the mother-to-be might be taking; birth defects may result from taking certain medicines
- discourage smoking and drinking alcohol; growth of the baby can be affected, and birth defects may arise from these practices
- do treatments as ordered, such as blood pressure, temperature, pulse, and respiration; record and report any unusual readings
- observe the mother-to-be carefully for signs of bleeding if there is a threat of miscarriage and for any severe pain; report these immediately
- encourage good personal and dental hygiene
- try to help the mother-to-be to feel as optimistic as possible; try to provide a calm environment for her to help her general feeling of well-being
- encourage exercises as allowed
- help her maintain a good fluid intake for her general health
- teach her how to use good body mechanics.

Postpartum Care

When the homemaker-home health aide is in the home soon after delivery, it is usually because special care is needed by the mother or baby because of risk factors or because care of the family would be too demanding of the mother's strength. The following are factors to be considered in working with the new mother:

- emotional changes may range from depression to elation in both parents; the mother may be irritable and weeping at times; be understanding and patient
- relieve the mother by helping to care for the baby and other children as needed, so the mother gets adequate rest
- involve the family in the care of the new baby to help in family adjustment
- help with home management activities as needed to assist the mother
- encourage the mother to:
    - . wash the breast first with a rotating motion
    - . eat a balanced diet
    - . get adequate rest and exercise
    - . interact with the family unit
    - . take time to get to know her baby
- watch for signs of infection (pain, elevated temperature, or foul odor to the vaginal discharge), and report any of these signs or symptoms immediately
- watch for vaginal bleeding; the discharge should change from bright red to pink to white within several days; report excessive bleeding immediately.

Part 2: Caring for the Baby

Demonstrate how to pick up and hold the baby, using a doll for demonstration.

To pick up the baby:

- put one hand under the buttocks
- put the other hand under the head, neck, and shoulders

- raise the baby gently towards your body
- avoid sudden, jerky movements.

Shift to the football hold:

- continue the support to the baby's head, neck, back and buttocks
- swing the baby to the side to rest on the hip on the same side as the hand that is providing support to the head
- leaves one hand to pick up articles, adjust blankets, etc.

Have the students practice picking up and holding the "baby".

Demonstrate feeding and burping the baby.

If the mother is breast-feeding the baby, she will probably already have established a routine. If she needs help, remember to have her:

- wash hands before breast-feeding
- wash the nipples with warm water and a soft cloth before feeding; a daily shower should be adequate, but be sure the nipples are rinsed well if soap is used
- make sure baby is dry and comfortable before feeding
- help the baby find the nipple: tickling his cheek nearest the nipple will help him turn his head towards it
- help the mother to find a comfortable position
- burp the baby by:
    - . placing him face down, upright on the lap, or at the shoulder for burping, gently rubbing or patting his back
- record the reaction to feeding: was there nipple pain? does the baby seem full?

For bottle-feeding:

- wash hands
- prepare formula as directed
- make sure equipment is clean and/or sterile according to the supervisor's directions; use aseptic or thermal sterilization, if sterilization is required
- make sure baby is dry and comfortable before feeding

- cradle the baby in a comfortable position

- burp baby

- record the amount of formula taken and reaction to the feeding (eager to eat, not interested in eating, etc.).

Bathing the Baby

The next demonstration is bathing the baby. Write on the board equipment needed: tub or kitchen sink, bath tray, toilet articles—soap, cotton, towel, washcloth, baby lotion, clean clothing. Have each trainee return the demonstration. Watch that the hot water faucet is turned away from the baby if the kitchen sink is used.

Note: Baby will require a sponge bath until the navel is healed. Special care may be needed for the circumcision until it is healed. Procedure:

- wash hands

- prepare the environment; it should be draft-free and warm

- bath water should be at 100 degrees F (37.7 degrees C)

- prepare baby for the bath: bring him to the area, undress him, and cover him with a towel

- wash scalp, rinse, and dry

- wash face, neck, and ears with plain water

- clean nostrils

- put baby into the tub (after navel is healed)

    - wash his body, making sure creases are clean

    - wash between labia for the baby girl

    - if the boy baby is not circumcized, pull back the foreskin carefully, and cleanse the penis

    - follow orders for care of the circumcision

    - dry carefully in all creases

- examine nails, push back cuticle and cut nails, preferably when baby is asleep

- add lotion and/or powder as needed to the body.

Care of an older child or baby is given according to the direction of the physician. Include foods only as suggested. Follow other established routines for bathing and sleeping.

Stress the importance of immunizations for the young child.

The following immunizations for children are recommended by the Center for Disease Control:

Age	Type of Immunization
2 months	DTP* Polio
4 months	DTP* Polio
6 months	DTP* **
15 months	Measles, mumps, rubella (only one shot is needed of each. Some physicians give a combination injection in a single shot, MMR)
18 months	DTP* Polio
4 - 6 years before starting school	DTP* Polio
	Diphtheria/tetanus booster should be given every ten years or following a dirty wound if a booster has not been given in the preceding five years.

* DTP: diphtheria, tetanus, and pertussis (whooping cough)

** Some physicians give one additional dose of polio when the child is six months old.

SUGGESTED REFERENCES

American Red Cross. Family Health and Home Nursing Textbook, Garden City, New York: Doubleday, Publication date pending.

American Red Cross. Preparation for Parenthood Instructors Guide. Washington, D.C.: The American Red Cross, 1976.

Dickason, Elizabeth J., R.N., M.A., and Martha Olsen Schult, R.N., M.A. (eds). Maternal and Infant Care. New York: McGraw Hill, 1975.

Salk, Lee and Rita Kramer. How to Raise a Human Being. New York: Warner Books, 1974.

U.S. Department of Health, Education, and Welfare, Public Health Service, Communicable Disease Center. "Childhood Immunization Checklist". July, 1977.

ASSESSMENT

1-3. Name three things the pregnant woman should do to improve her health and the baby's.

____

____

____

4-5. When the pregnant woman is on bedrest what are two signs to watch for that could mean a serious complication?

____

____

6-8. Name the positions for burping the baby.

____

____

____

Circle the correct one:

9. False/True The baby will require a sponge bath until the navel is healed.

10. False/True It is easier to cut the baby's nails when he is awake.

11. False/True The circumcision needs no special care.

12. False/True Immunizations should be started just before the child enters school.

ANSWERS

1. Eating a balanced diet.
2. Stopping smoking.
3. Not drinking alcoholic beverages.
4. Infection.
5. Bleeding.
6. Face down on the lap.
7. At the shoulder
8. Upright on the lap.
9. True.
10. False.
11. False
12. False.

AIDS

Exercise 1: Basic Need Factors for Mothers, Newborns, and the Family

Discussion Questions 1: Mother and Baby Care

Exercise 1: Basic Need Factors for Mothers, Newborns, and the Family

The purpose of this exercise is to explore the basic needs of families with newborn infants.

- Have the trainees list the basic needs and any special needs created by the additional family member.
- List them on a flipchart or board, using the following headings:

Needs	Infant	Sibling(s)	Mother	Father
Basic:				
Special:				

- Discuss specific knowledge and skills required.

Discussion Questions 1: Mother and Baby Care

1. Discuss the health care measures the pregnant woman should follow to maintain and improve her health.
2. What are some of the factors the homemaker-home health aide must consider in taking care of a mother and a new baby?
3. How can the father and other children be included in care of the mother and baby?
4. Discuss the important points to follow in holding the infant.
5. Discuss the importance of immunization.
6. What points are important to remember in bottle-feeding the baby?

SECTION V

APPLICATION OF KNOWLEDGE AND SKILLS - PRACTICUM

Section V is a continuation of the learning experience in which the trainee has an opportunity to integrate understanding and knowledge of working with people and the practical skills of home management and personal care in service to individuals and families in their own homes.

APPLICATION OF KNOWLEDGE AND SKILLS - PRACTICUM

ESTIMATED TIME: 15 hours

SUGGESTED INSTRUCTOR: The instructor or instructors for this unit will depend upon local planning and agreements regarding responsibility for the field practice. The course instructor or coordinator may participate and should coordinate the field practice. Agency personnel may supervise the practice according to availability of staff. It is most desirable that a nurse supervise the personal care skills. (See pages 2 and 5 for further suggestions.)

INTRODUCTION

The field work aspect of the training program is designed as a practical learning experience for the trainee to utilize the skills and knowledge gained through laboratory and lectures in actual services to individuals and families. It is also designed to assist with the further development of positive attitudes needed to provide services to individuals and families and experience the role of homemaker-home health aide in its totality. This can best be achieved by supervised field practice. That is, field visits are made to individuals and families in their homes. An instructor is present to observe and help the trainee when further instruction is needed.

The goal of field instruction is to reinforce and help integrate learned skills and knowledge. It takes place under the guidance of the field instructor or an agency staff member. The field experience should provide additional learning experiences as well as an opportunity for the trainee to demonstrate what has been learned. Cases should be carefully selected to ensure that the objectives intended are met and are coordinated with and reinforce learning experiences gained from the preceding units of instruction. In addition, the opportunity to work with the care team can further clarify the homemaker-home health aide role. The environment of the agency itself provides a learning experience for the trainee.

The practical learning experience will vary in accordance with the overall training plan. If a learn-work plan* is in effect, then supervised practice may take place as the trainee moves from the simple to more complex cases using opportunities for specific kinds of experience as these are available. The objective of reinforcing and integrating skills and knowledge must be maintained. When training takes place outside of the agency as a continuous full-time course, it may be more convenient to schedule a specific block of time for field practice. This may be particularly true when training takes place in a community college with open enrollment, admitting registrants not yet employed by an agency.

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* Trainees go to classes half-time and work half-time, or some other combination of hours.

The instructor-coordinator for the training course should be responsible for planning and coordinating the field practice. When it is necessary for a "special" instructor, i.e., the nurse or a staff member of the agency to provide field guidance, that individual should be carefully oriented to the purpose of the field experience, the expected outcome for the trainee, and the expected level of performance, including limitations.

Field practice should be concentrated and planned so that the trainee will have a working knowledge of the scope of the homemaker-home health aide role and how it relates to the overall program of the agency.

EXPECTED OUTCOME

For all visits the trainee will be able to:

- prepare and plan for a visit to the home
    - . call the family to assure that visit is expected
    - . know how to dress properly
    - . assemble needed supplies
    - . review the record - ascertain the plan of care and associated assigned tasks. Consult staff members if necessary
- establish a relationship by being sensitive to individual needs and respecting the family's life style
- provide services specified in the care plan, using learned skills and knowledge
    - . organize work to conserve time and energy
    - . work safely and effectively
    - . leave the home or ill person's room neat and clean
    - . respect the independence of the individual

- help the family accept and carry out needed care and treatment as found in the plan of care
- report and record activities performed, observe conditions and any changes and problems not previously known to the agency
- work with the care team or supervisor in an effective and productive manner to provide needed services
- know what procedure to follow if an emergency arises
- recognize the need for services provided by other agencies in the community

EQUIPMENT/MATERIALS

Movie or slide projector.

CONTENT

Part 1: Orientation to Field Practice (1 hour)

The instructor may now show a movie which describes the homemaker-home health aide role. It could be one which was used at the start of the course; such as "A Better Answer" available from the National Council for Homemaker-Home Health Aide Services, Inc.

Provide handouts giving information about the field practice agency, i.e., addresses, staff names, working hours, personnel policies, and other essential information. The purpose of field experience and expected outcome should also be provided in written form.

The purpose of this section is to provide an overview of the field practice component. The field experience should help to identify trainee expectations and help the trainee to gain the experience that he or she wants. It helps the trainee gain assurance in working with families and practicing learned skills in the "real" situation. The practicum is an integral part of the learning experience designed to integrate and reinforce what has been learned and add new and different knowledge. It allows for additional help and information as needed by the instructor. In a very different way, it assists the trainee in knowing how to approach the family, introduce him/herself, converse with the person(s) in the home ("How are things today?" and "What has happened since my last visit?") - and to explain what tasks or duties are to be performed. The homemaker-home health aide trainee will also learn how to solicit individuals' comments or suggestions.

The orientation should provide specific information about the field agency,* its organization and its purpose in the community and services provided, its organization and staffing, its policies or procedures that may affect the trainee in field practice, its expectations of agency personnel such as confidentiality, promptness and its policies regarding referral and use of other community resources for the individual or family served.

Part 2: Guide for Field Instructors

The field instructor may be a member of the agency who has not been intimately involved in the training program. It would be desirable for the person from the agency to participate in all meetings of instructors. Therefore, some guides are suggested: These include:

- rientation to the concept and philosophy of the field experience and its relationship to the total training program emphasizing that it is a learning experience as well as an opportunity to practice and integrate what has been learned
- ertinent information about the trainee can contribute to the field experience to make it most meaningful for the trainee
- ases selected for field experience should not be too complicated while at the same time allowing for the use of and integration of several skills in a well-planned visit
- ssessment of the outcome of the visit may be done in conference with the trainee, giving the trainee an opportunity to evaluate her own progress in terms of the expected outcome
- ssessment of progress should take place after every visit
- report for the field practice period should be given to the coordinator for the course to use in the overall evaluation. Identification of needed additional skills not included in the basic course could be the basis for revision and additions to the course

Part 3: Case Selection for Field Practice

In addition to the general outcomes that are applicable in most

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* If the trainee is a member of the agency, it may be omitted.

instances, certain additional outcomes relate to various types of cases that may be selected for field experience. Some units of the Personal Care Section suggest supervision of specific procedures in the field. The instructor may wish to include these in field practice.

Child Care

Case selection should provide an opportunity to use skills and knowledge in meeting the needs of both the normal child and the one with unusual needs.

EXPECTED OUTCOME

The trainee is able to:

- relate the care needs of children to their growth and development
- provide emotional support as well as physical care
- observe unusual situations that affect the health and safety of children -- the relationship of parents and children and the ability of parents to provide the care and love children need
- use teaching skills to help families solve problems involving home management and nutrition
- act so as not to disturb the usual relationship between children and parents unless to strengthen it

Care in Short and Long-Term Illness

Case selection should emphasize basic concepts in the application of skills when individuals have problems of short and long-term illness.

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EXPECTED OUTCOME

The trainee will be able to:

- demonstrate ability to observe and show sensitivity to problems of illness
- help the family carry out special treatment in which she has been instructed by the nurse, the physical therapist or other member of the health care team

- prepare a modified diet if indicated in the plan
- record service given and observation of any changes
- be aware of and be able to handle feelings, especially about terminal illness

Care of the Elderly

Case selection should give the trainee an opportunity to use insights and skills needed to provide care and services to the elderly in their own homes.

EXPECTED OUTCOME

The trainee will be able to:

- demonstrate a positive and accepting attitude toward aging
- relate the care and supportive needs of the elderly to common human needs as well as to special physical, psychological and social changes which may affect the elderly
- help the aged person to live safely, independently and with dignity in their own homes

APPENDIX I

MODULE A: Cancer

SUGGESTED INSTRUCTOR: Physician, Nurse, Social Worker, Staff from the Local Cancer Society

INTRODUCTION

Since there are many people with cancer, and since many are living longer, the homemaker-home health aide will have many opportunities to help them live as fully and comfortably as possible. Therefore this unit is designed to provide the homemaker-home health aide with some facts about cancer and the skills needed to meet the needs of individuals and families. It does not include discussion of the many and varied manifestations of the disease except in a general way. Rather, the emphasis is on those concepts which will enable the homemaker-home health aide to give needed care to the affected individual and to support the family as its members cope with the emotional trauma of the diagnosis and after-care.

EXPECTED OUTCOMES

The homemaker-home health aide will be able to:

- provide the affected individual who has cancer with the supportive physical care needed

- establish a supportive but matter-of-fact relationship with the person who may have had radical surgery for cancer in ways that encourage as normal a life as possible and that will help to ease the distress of the family

- help the family deal with feelings of fear and helplessness toward the diagnosis of cancer

- help and support the individual and family to carry out the plan of care and learn more effective ways of caring for the person with prolonged illness.

EQUIPMENT/MATERIALS

Contact the American Cancer Society for updated material before teaching the module.

Slide projector

Movie projector

CONTENT

This discussion covers general concepts about cancer and its signs and treatment.

Cancer is often thought of as a modern disease caused by pollution, chemicals or radiation; however, it is one of the ancient diseases of mankind.

The body is composed of minute cells which make up the various organs. When these cells grow in an irregular way, masses are formed, called tumors. The tumors may or may not be cancer. Why this happens is not known. Cancer is a malignant tumor. The basic nature and origin of cancer is complex. Detected early, many cancers can be cured. Detected late, the goal in treatment is to keep the person as comfortable as possible.

Cancer can affect all parts of the body. Breast cancer is a leading cause of cancer deaths in women. Other frequently involved areas of the body are the colon, rectum, bladder and the stomach. Leukemia, cancer of the blood, is often the tragic cause of death in children.

Cancer is found at all ages and is a principal cause of death in children. Half of all cancers are curable if diagnosed early. Research is providing an increasing amount of information about factors which may be involved in the development of cancer. Smoking, for example, outweighs all other factors as a possible cause of lung cancer. Cancer is not contagious. The three leading causes of death from cancer in men are lung, colon, rectal and prostate cancer. The three leading causes of death from cancer in women are breast, colon, and rectal and lung cancer. Leukemia is cancer of the blood-forming tissues. Often thought of as a childhood disease, it strikes many more adults than children. Because of research and treatment many are living 5 to 10 years longer.

Some signs of cancer may be:

- unusual bleeding or discharge
- a lump or thickening of the breast
- a sore that does not heal
- changes in bowel or bladder habits
- indigestion
- difficulty in swallowing
- changes in a wart or mole
- nagging cough or hoarseness.

Although individuals react differently to a diagnosis of cancer, there is always shock, with a special, severe kind of stress and a deep fear of the pain and death generally associated with cancer. Although there is frequently depression in illness, this is always a factor in cancer diagnosis. There is a feeling of anger that this should happen to them.

See Section II, Unit D.

Treatment usually consists of surgery, chemotherapy and radiation, either alone or in combination. It is often drastic and trying to the patient. Sometimes treatment takes place over a period of weeks and months, adding to the stress and anxiety for the individual and family. The following describes the three forms of treatment.

Surgery

The surgical removal of a malignant tumor is the oldest form of treatment for cancer. It is used for taking a biopsy, removing a tumor, relief of symptoms and reduction of pain. Radical surgery means the removal of the tumor itself, surrounding tissue, skin, lymph nodes and blood vessels. People who undergo radical surgery fear rejection, especially if it results in deformity. There is a feeling of grief for the loss of a part of the body or use of that part, loss of a limb, loss of voice, loss of bladder and bowel control.* Encouragement in living as normally as possible becomes an important supportive effort.

Most persons who have experienced radical surgery will have received special instructions for self-help care before leaving the hospital or may have been referred to the local unit of the American Cancer Society for special services available for various forms of cancer. Examples are "Reach to Recovery" programs for mastectomy patients and speech instruction for persons who have had the larynx removed. These services provide group support and educational activities, as well as dressings and special appliances.

Radiation

Radiation is used for treatment if the cancer is localized in one or more areas of the body. The rays enter the body and kill cells by interfering with normal function, making it difficult for cells to multiply and grow. Normal cells are also affected, but these grow back and cancer cells are killed. Radiation treatment is not painful, and the person does not become radioactive. Treatments usually last 2 to 6 weeks. During this time the person may need special care of the skin. The treatment plan should be followed, to provide special care of the skin and measures to relieve side effects if present.

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* Ogg, Elizabeth. When a Family Faces Cancer, Public Affairs Pamphlet No. 286, p. 4.

Chemotherapy

Cancer chemotherapy alters the life cycle of the cell. The drugs may be given orally or by a needle into the vein. In some cases chemotherapy can cure, in others it can prolong life and relieve pain for months, even years. Some persons have side effects, such as nausea, vomiting, diarrhea and fatigue. Colds and infections should be avoided.

How the homemaker-home health aide fulfills an important supportive role and provides for the personal care needs of the individual: see Section IV, Units E and H.

The homemaker-home health aide can help the individual and family by using her understanding and knowledge of human needs and skills when personal care and home management are needed. It is important to ascertain what the individual is being told and how the family and doctor are handling information regarding the illness. The homemaker-home health aide must exhibit patience and understanding, especially in helping the ill person to adjust to increasing limitations when the disease is progressive. When possible, help individuals to live as nearly normal lives as they can by returning to normal activities. The homemaker-home health aide should be understanding but firm in helping with treatment and the establishment of new routines and new ways of life. Maintaining good nutrition is especially important. Diet is of concern in establishing bowel routine after colostomy surgery and in maintaining strength for those with terminal illness. The family may need support in its efforts to cope with the situation and to help the individual with needed routines and treatment necessary for living as normal a life as possible. Although the homemaker-home health aide will have feelings for the individual and family, these feelings of shock, grief, or despair should not be allowed to distress the family further. In order to be most helpful, the homemaker-home health aide needs to have a detached, but at the same time sympathetic, attitude.

Slides and movies: The local unit of the American Cancer Society should be contacted for films and slides that may be available in the local community. Suggested films are "Self-Breast Examination", "The Embattled Cell", and "People with Colostomies" (related to attitude).

Handout suggestions: Literature from the American Cancer Society; also "When a Family Faces Cancer", Public Affairs Pamphlet No. 286, by Elizabeth Ogg, 1976 (especially useful is the presentation of how two families face cancer).

Exercise 1: Meeting the Needs of Cancer Patients - Case Discussion

The following two cases may be used for a discussion or role-play to help the homemaker-home health aide understand the physical and emotional needs of the cancer patients and the dying person. Both are terminally ill.

- How do the needs of the two ill individuals differ?
- What human needs are expressed, and how did the homemaker-home health aide respond?
- What kind of knowledge and skills were needed in each case?

Case for Discussion

Mrs. Brunetto, the homemaker-home health aide, reported that Mrs. Fianzzo, suffering from terminal cancer, seems increasingly irritable and unhappy. The children, when they return from school, hang around the kitchen with Mrs. Brunetto and seem reluctant to spend any time in their mother's room. The mother cries and yells at the children, accusing them of not wanting her any more. Then she demands unusual attention from Mrs. Brunetto when she is preparing the evening meal. The homemaker-home health aide understands that Mrs. Fianzzo is extremely fearful about her deteriorating health and expressed a wish that the case worker and the nurse would call at the home at least once a week.

Case for Discussion

Mrs. J. was suffering from terminal metastatic cancer. She realized the status and extent of her illness and desired to remain at home for her final days. Her family, consisting of only her husband and her mother-in-law, were most anxious and able to comply with her wishes, but only if they could have the technical and professional help and support of the public health nursing agency and homemaker-home health aide service. The alternative was that she remain in the hospital until her death. Almost one hundred percent of the homemaker-home health aide's time was spent in personal care, bathing, force-feeding, general comfort and staying with Mrs. J., who was reluctant to be left alone, so as to allow the family members to leave the house occasionally and the husband to keep working.

Module B of Appendix I follows.

MODULE B: Diseases of the Circulatory System

SUGGESTED INSTRUCTOR: Physician, Nurse

INTRODUCTION

This unit is designed to provide the homemaker-home health aide with basic concepts about diseases of the circulatory system. Already-learned knowledge and skills for working with the ill and disabled and providing personal care and rehabilitation services can be more effectively applied with added knowledge about heart disease, hypertension, stroke and other diseases. The homemaker-home health aide will be better able to understand the problems of the individual and family when these illnesses are present.

EXPECTED OUTCOME

The trainee will be able to:

- function under and contribute to the plan of care designed for the individual with a disease of the circulatory system, giving support during periods of anxiety
- identify and understand various terms used in describing conditions of the circulatory system
- use general knowledge about diseases of the circulatory system to apply learned skills in personal care and rehabilitation of the individual
- observe and report reactions to treatment and changes in the individual's condition to the supervisor
- assist the individual and family to maintain as normal a life style as possible within limitations that may be imposed by the illness.

EQUIPMENT/MATERIALS

projectors - slide and movie
sphygmomanometer
model of the heart
diagram of the circulatory system

CONTENT

Coronary heart disease, rheumatic heart disease, congenital heart disease, stroke, congestive heart failure and hypertension are among the diseases of the circulatory system.

Review Section IV, Unit A.

The heart is a muscular organ about the size of your fist that pumps blood through the arteries to bring nourishment and oxygen to the body cells and removes waste from the cells, returning the blood to the heart through the veins.

The right side of the heart receives the blood from the body and pumps it into the lungs to remove carbon dioxide and take on oxygen. The left side receives the blood with renewed oxygen from the lungs and sends it to the body. The blood completes this cycle in about 60 seconds.

Arteriosclerosis is a narrowing and thickening of the lining of the arteries caused by an accumulation of fatty and other materials deposited on the inner lining. As the vessels thicken they become brittle and lose elasticity. This can cause a stoppage of the blood flow by the formation of a clot or by narrowing and a closure of the blood vessel. Arteriosclerosis is responsible for most heart attacks and angina.

Heart attack (medically referred to as coronary thrombosis, coronary occlusion, or myocardial infarction) is an acute condition brought on by a sudden blockage of the supply of blood to a part of the heart. The blood supply may have been cut off by a blood clot or the artery may have become so narrow that the blood supply to the heart muscle is reduced or cut off. Although it may seem sudden, the coronary disease has been building up for years. The heart can mend itself after an attack by an unusual repair set-up called collateral circulation. Nearby arteries get wider and new branches are formed to bring blood to the heart itself.

A heart attack is a frightening experience for both the person having the heart attack and the family.

Angina pectoris is a temporary chest pain caused by a diminished blood supply to the heart muscle. The individual experiences a sensation of tightening in the chest and pain which may radiate to the neck, shoulder and arm. The pain vanishes in a few minutes after rest. The person may experience a lot of fear. People who have angina usually carry nitroglycerine which relieves the pain.

Congestive heart failure occurs when the heart is unable to produce a flow of blood sufficient to meet the needs of the body. It is the eventual outcome of most forms of heart disease. The most frequent causes are chronic hypertension, valve defects and myocardial infarction. It may be acute, but usually it comes on gradually. Onset may be brought on by a respiratory infection, excitement or exertion. Blood gathering in the lungs causes shortness of breath, swelling of the ankles (or edema), changes in pulse rate and consistency. Congestive heart failure can improve with treatment. It can occur at any age, but is often found in the elderly.

Hypertension (high blood pressure) is a major factor in heart disease. Blood pressure is the force with which blood pushes against the walls of the blood vessels. This force is determined by the size of the vessels. Hormones and chemicals regulate the size of the blood vessels while certain nerves keep the pressure steady (sympathetic).

High blood pressure (hypertension) is when there is a permanent tightening of the arteries. The physician determines whether there is a case of hypertension on the basis of his examination. Although the cause of high blood pressure is unknown, many factors may influence it - life style involving stress, heredity, excess of salt and fats in the diet. Anyone can develop high blood pressure, but most frequently it develops between the ages of 30 and 50.

The most common causes of a stroke, or cerebrovascular accident, are the rupture of a blood vessel resulting in hemorrhage into the brain tissue, the blocking of a blood vessel by a blood clot, and pressure by a tumor or the effect of an accident. The onset is sudden, with loss of consciousness lasting minutes to hours. The person who has a stroke may be only slightly or seriously affected. The common results are:

- weakness of muscles on one side of the body
- loss of vision in one eye
- problems in talking
- problems in controlling urine or bowels
- loss of senses of position, pain, temperature and touch.

These problems may last for several days or many months, and in some cases for the rest of life.

The care and rehabilitation of the person who has had a stroke is challenging and rewarding, and one in which the homemaker-home health aide may be an effective source of treatment. Since the incidence of stroke is high, especially among the elderly, the homemaker-home health aide will sooner or later be involved in providing services to a person who has had a stroke.*

Treatment should be started early and continued over a period of time. In addition to the physician and nurse, the treatment team may include a physical therapist and speech therapist, depending upon the parts of the body affected by the stroke. The homemaker-home health aide will be involved in:

- carrying out the plan of treatment, exercise and activities developed by the professional team.
  See Section IV, Unit G, Rehabilitation.
- special concerns:
  - . preventing the disabled limb from becoming deformed

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* Ramey, Irene C., R.N. "The Stroke Patient is Interesting." Nursing Forum, Vol. VI, No. 3, 1967, pp. 273-279.

- getting disabled parts moving again - by passive and active exercise and range of motion, by having the individual do daily activities, such as dressing, feeding himself, on his own and encouraging the individual to use his good hand to exercise the other hand *See Section IV, Unit G*

- helping to regain balance because of loss of sense of position

- helping the individual to talk

- maintaining nutrition - foods and fluids are needed to keep the body functioning and to rebuild tissues that may have been destroyed. The diet prescribed by the physician may depend upon other health factors, such as weight, blood cholesterol, etc.* If the facial and throat muscles are affected, there may be difficulty in eating and swallowing. Several small meals may be necessary when the person has difficulty eating and tires easily.*

- helping the family to accept and cope with the limitations resulting from the stroke. The individual's strengths should be emphasized in the orientation of the family and in the rehabilitation plan for the individual

- adapting the household to the limitations of the person who has had a stroke may be an important function of the homemaker-home health aide. This includes having utensils arranged in the kitchen so that the individual can prepare meals.

Some general care factors that apply to most persons with diseases of the circulatory system follow.

The person with a disease of the circulatory system will have a carefully designed medical treatment plan that meets his specific needs. Usually such a plan includes:

- arrangements or a schedule for close medical supervision

- medications carefully prescribed in terms of dosage and scheduled to meet the specific individual's treatment needs

- observations of the blood pressure and pulse

- specific instructions for exercise, relaxation, and rest

- modifications of the diet - such as low-sodium and/or low fat.

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* Simplified Diet Manual - Study Guide. Iowa State University Press. Prepared by Dietary Consultants of the Iowa Department of Health, 1978, pp. 18-19.

The role of the homemaker-home health aide in assisting the individual with circulatory disease and his family may be crucial to recovery and rehabilitation. A heart attack or stroke is a frightening and emotional experience. Both the individual and his family need encouragement and support in their efforts to return to as normal activities as possible. Many of the needed skills were learned in the basic training program and include:

- meticulous adherence to the plan of care and assisting the family to carry out its responsibility for care
- preparing and helping the family to prepare the prescribed diet (*Section IV, Unit F*)
- emphasizing the importance of medications to be taken as directed
- assuring that patient follows direction for daily activities and exercise
- encouraging self-care and return to as normal a life style as possible
- observing and reporting changes in the individual's condition (*Section IV, Unit B*) and reactions to medication
- helping relieve the anxiety of family members and making adaptations necessary for the recovery and rehabilitation of the affected person (*Section IV, Unit G*)
- developing adaptive materials and equipment for the person who has had a stroke (*Section IV, Units E and G*)
- knowing what to do in emergencies (*Section IV, Unit H, Part 2*)
- knowing the community resources that are available to individuals and families.

SELECTED REFERENCES

Irvin, Theodore. Understand Your Heart. Public Affairs Pamphlet No. 514. 1974. 381 Park Avenue South, New York, N.Y. 10016.

Ramey, Irene, R.N. "The Stroke Patient is Interesting." Nursing Forum, Vol. VI, No. 3, 1967, pp. 273-279.

Simplified Diet Manual - Study Guide. Iowa State University Press. Prepared by Dietary Consultants of the Iowa State Department of Health, 1978, pp. 18-19.

The Channing L. Bete Company, Greenfield, Mass. 01201
You and Your Heart. pp. 15.
You and Your Blood Pressure. pp. 15.

Klinger, Judith. Mealtime Manual for People with Disabilities. Institute of Rehabilitation Medicine, New York University Medical Center and Campbell Soup Company, 1978, pp. 269.

ASSESSMENT

1. Name 3 diseases of the circulatory system:

____________________ ____________________ ____________________

2. When a person has arteriosclerosis the lining of the arteries ____________________ and ____________________.

3. Coronary thrombosis and myo-cardial infarction are commonly referred to as ________________________.

4. Congestive heart failure is when the heart is unable to produce a ____________________ of blood to the tissues. Persons may develop ____________________ of the ankles called ____________________.

5. A stroke comes on ____________________.

6. A person who has had a stroke may have:

____

____

____

7. Five general factors that apply to most people with circulatory disease:

____

____

____

____

____

8. What are some factors that may influence blood pressure?

ANSWERS:

1. Any of these: high blood pressure, heart attack, arteriosclerosis, stroke.

2. Narrow and thicken.

3. Heart attack.

4. Flow - swelling - edema.

5. Suddenly.

6. Weakness in one side of the body;

   problems in talking or problems in controlling urine and bowels;

   loss of sense of position, touch.

7. Any of these: close medical supervision, medications, instruction for exercise and rest, modified diets, observe blood pressure and pulse.

8. Life style;

   heredity;

   excess of salt or fats in diet.

Exercise 1: Meeting the Needs of Persons with Diseases of the Circulatory System

The homemaker-home health aide will frequently provide services in a home where a person has had a heart attack, a stroke, congestive heart disease or high blood pressure. The three cases for discussion include all of the above conditions. The exercise may be used to role play each situation or for discussion. Points to emphasize:

- identify the reactions to illness in each case;
- describe what needs were exhibited by each of the sick persons; by their families;
- indicate how the plan of care for Mrs. Henry would differ from Mrs. Manopolis;
- indicate the specific care that was indicated in each case.

* * *

Mrs. Manopolis, a 66-year-old widow of Greek extraction, living alone, was referred for home care services following a second myocardial infarction. A visit was made by the home care doctor on the day she was discharged from the hospital. At that time she was very emotional and anxious, and it was evident that she would need a lot of support. The social worker arranged for a homemaker-home health aide and financial assistance.

Mrs. Manopolis was not proficient in the English language, so was very confused about the drugs prescribed. The nurse helped the homemaker-home health aide develop a system by which she could help Mrs. Manopolis remember to take her drugs correctly. The nurse also helped plan the sodium-restricted diet, taking into consideration Mrs. Manopolis' eating habits and cultural background. Even so, Mrs. Manopolis would eat salty food such as potato chips when she was alone.

At first, the homemaker-home health aide spent four hours a day in the Manopolis home. When Mrs. Manopolis was able to walk a block and take her own bath, the homemaker-home health aide's time was reduced to two hours, twice a week.

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Mrs. Henry, a 37-year-old wife and mother, had been left paralyzed on her right side and speechless. She had been hospitalized for seven months. Her discharge from the hospital depended upon the assignment of a homemaker-home health aide. This service made it possible for the father to continue his employment and the children aged 11 and 8 to attend school without interruption.

The primary duties of the homemaker-home health aide were the full care of the mother. This included getting her out of bed, a sponge bath, dressing, assisting her from bed to wheelchair and from wheelchair to the sofa, preparation of her breakfast and lunch. She was assisted to and from the bathroom and given simple exercises under the supervision of the public health nurse.

* * *

Mr. and Mrs. Coats, ages 83 and 71, respectively, live in a four-room apartment. A married daughter lives about one mile away. She works full-time as the main support of her family of five. Her husband has been out of work for six months, and two sons are attending the community college and living at home.

Mr. Coats was hospitalized for two weeks for congestive heart failure. Although he was much improved when he came home, he was still short of breath and unable to wear his shoes because of his swollen feet. It is still difficult for him to carry out activities of daily living.

The Coats' were able to manage until Mrs. Coats had to be hospitalized for surgery on her eye. She was also treated for hypertension. Now her vision is very limited and she is unable to read, which she had enjoyed doing.

Because Mr. Coats was unable to care for himself when Mrs. Coats was hospitalized, a homemaker-home health aide was assigned for four hours a day, five days a week, to help maintain Mr. Coats at home. In addition to helping with activities of daily living, she shops twice a week, does the laundry, prepares the noon meal and sandwiches for supper.

It was necessary to continue the homemaker-home health aide services after Mrs. Coats returned home since she was unable to carry on as before. Both now are on modified diets and medications. Mr. Coats receives a drug prescription for his heart and a medication to remove the fluid from the tissues. Mrs. Coats has medication for hypertension.

Handout 1: Suggested Pamphlets for Use by Homemaker-Home Health Aides

There are a number of popular publications about the heart and other conditions of the circulatory system. Some may be obtained from the local heart association. The Channing L. Bete Company, Inc., 45 Federal Street, Greenfield, Mass. 01301, publishes booklets that present materials graphically for easy reading and understanding by the general public. These include:

You and Your Heart

You and Your Blood Pressure - 25¢ each

Public Affairs Committee, Inc., 381 Park Avenue South, New York, N.Y. 10016, has a publication that would be useful as a handout for the homemaker-home health aide trainees:

Understand Your Heart - Pamphlet No. 514

All of the above are available at reduced rates when purchased in quantity.

Appendix I, continued

MODULE C: Developmental Disabilities

SUGGESTED INSTRUCTOR: Mental Health Team Member(s), Public Health Nurse, Social Worker, Special Education Teacher, Staff of Organization for Mentally Retarded, Psychologist

INTRODUCTION

This unit is intended for the instruction of the experienced homemaker-home health aide who has completed a basic training course. It is designed to provide the homemaker-home health aide with learning experiences, added knowledge and skills needed for effectively caring for the developmentally disabled. The previously learned skills and knowledge of how to work with people, establish relationships and the personal care of individuals will be applicable and form the basis for the additional instruction. The added learning opportunities should increase the homemaker-home health aide's ability and assurance in providing the needed supportive services in the home of the developmentally disabled.

The materials presented describe two of the common forms of developmental disabilities that concern the homemaker-home health aides, associated problems and care needs of the individuals and their families. If programs include other developmental disabilities, these may be included. In addition to assisting the mother or caretaker in the care and training of the individual with developmental disabilities, the homemaker-home health aide should be able to relieve the mother or other responsible person so that she may go shopping, undertake necessary errands and have time for recreational activities.

EXPECTED OUTCOME

The homemaker-home health aide will be able to:

- demonstrate a knowledge of the problems and needs of a person with a developmental disability
- accept the individual with a developmental disability
- help the family accept and cope with the stress factors involved in caring for a handicapped child and assist them to help the individual achieve maximum self-care
- help the family understand the capabilities and limitations of the handicapped person
- help the individual develop to the best of his ability through carrying out a plan developed by the professional team together with the individual and family:

- which assists in developing self-help skills (examples are eating and toileting)
- which uses techniques for behavioral change
- which uses techniques that encourage repetition in doing a task
- which helps individuals with communication skills by talking and listening to them
- which insures that the safety of the individual is at all times protected.

EQUIPMENT: Movie projector

CONTENT

The meaning of developmental disability and governmental involvement in the program will give the homemaker-home health aide a broad concept of the problem.

The developmentally disabled or handicapped include a large group of individuals who are disabled because of accidents or injuries that happened before or during birth or during infancy. For some, the causes can be found in various diseases or in the genes and cells. Sometimes the symptoms are evident at birth, but in other cases it is not evident until the child fails to accomplish steps in normal development, such as walking, talking and feeding himself. Some will have one disability, but many have a combination of disabilities.

Organized in 1949, the National Association for Retarded Citizens has proposed and influenced legislation, services for the retarded and attitudes toward developmental disabilities. National legislation, beginning in 1956 and 1957 and stimulated by President Kennedy in 1963, has emphasized the problem and helped to improve and expand the services for persons with developmental disabilities. The Developmentally Disabled Assistance and Bill of Rights Act of 1975, which deals with the provision of services and safeguarding of individual rights, was further revised in 1978.

According to the 1978 revision of the law, the term "developmental disability" means a severe, chronic disability of a person which:

(a) is attributable to a mental or physical impairment or combination of mental or physical impairments,
(b) is manifested before a person attains age 22,
(c) is likely to continue indefinitely,
(d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobil-

ity, self-direction, capacity for independent living, and economic self-sufficiency,

(d) reflects the person's need for a combination and sequence of special interdisciplinary or generic care, treatment and other services which are lifelong or of extended duration and are individually planned and coordinated.

The development of programs as a result of legislation encourages services to assist the persons who are developmentally disabled to stay in their homes.

Review Normal Growth and Development, Section II, Unit B, of the Model Curriculum as a basis for understanding the deficiencies in normal development and the needs of children according to age.

The mentally retarded individuals form a large group of the developmentally disabled. A child who is diagnosed as retarded performs below the average intellectually. The retardation appears in early childhood with the result that the child is slow to develop walking, talking and language skills.

Some characteristics include:

- the child is slow to sit up, pull up, crawl, walk, or toilet-train
- the child may have difficulty eating, chewing, and swallowing
- features which resemble the mongoloid races may be present
- behavior may be extreme (withdrawn or overactive) or no different from others
- the degree of retardation may be very severe in some individuals while in others only moderate
- certain tests may be applied to test the child's ability to determine strengths or weaknesses; the physician, pediatrician, well-child clinic, or social service agency may refer families to the available testing services in the community.

Why some individuals are retarded is largely unknown.

Some of the known causes include:

- infections
- exposure to radiation
- prematurity
- metabolic disturbances
- genetic defects
- some drugs taken during pregnancy
- RH incompatibility
- alcoholism in mother

Preventive measures are based on increased knowledge about factors that can contribute to mental retardation. Some risk factors associated with pregnancy include a maternal age under 16 years or a first baby after age 30, premature labor, and RH incompatibility. Proper care during pregnancy, including good nutrition, limiting exposure to x-rays, and controlled use of drugs are some preventive measures. Intensive-care nurseries and improved care assessment and testing of the newborn are other preventive measures.

Genetic counseling based on genetic testing is provided for parents who have family histories which predispose to developmental disabilities of children who may be born to them.

Increased experience and knowledge about the mentally retarded has led to efforts to help them lead a more normal life.

Normalization is a basic principle in modern treatment and care of the mentally retarded. That is, the mentally retarded individual should have as normal an existence as possible, based on a professionally developed plan that recognizes "the retarded person as an individual with human rights and needs; as an individual according to the age in years; and as an individual with special needs." *

This includes the right to his home and care by his own family, whenever possible. Experts in the field have found that a retarded child cared for by loving and stimulating parents has a higher level of development than one placed in an institution in infancy. **

Professional services and care for the retarded child living at home may come from one or more of the following:

- a team of mental health specialists, i.e., psychologist, mental health nurse, social worker, psychiatrist, of which the homemaker-home health aide may be an indirect participant
- special training facilities
- social services
- day-care centers
- family case worker
- the private physician.

In most communities, several professional workers may be directly or indirectly involved in the assessment of care need and plan for treatment. Each may have defined responsibility. Only one may be in direct contact with the family and the homemaker-home health aide.

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* Curry / Peppe. Mental Retardation—A Nursing Approach to Care. Principles of Normalization, by Kay F. Engelhardt. C. V. Mosby, 1978, pp. 33-35.

** Soyka, Patricia W. "Homemaker-Home Health Aide Services for Handicapped Children", Child Welfare, April 1976, Vol. LV, No. 4, pp. 245-246.

Each retarded individual should have a treatment plan which may be referred to as a "habilitation plan." It is based on a careful assessment by a professional team. The major concerns of such a plan are the physical health of the individual, the development of motor functions and daily living activities, the ability to communicate and to function in the social environment of which he is a part.

The plan should be clearly stated, with careful attention to detail, be related to the assessed needs, consider the needs expressed by the individual and his family, and be easily understood by them. Above all, it should be attainable. This means that the hoped-for goals must sometimes be reached by small, attainable, intermediate steps.

The homemaker-home health aide can make useful contributions to the plan on the basis of observations not only of the retarded individual, but of how the family responds both to the retarded person and to its responsibility for carrying out the plan. Such information can be useful in adapting plans to realistic and attainable levels. In some instances, the individual may be able to achieve at a higher level than indicated in the plan.

The homemaker-home health aide also contributes to the evaluation of the effectiveness of designed activities for reaching goals through her observations and work with the individual and family.

The meaning of developmental disability for the family is of primary concern in the work of the homemaker-home health aide.

The family's position is difficult. To the affectionate family, the handicap is a continuing grief and sorrow, and the grief may be accompanied by a feeling of guilt. To the indifferent family, the handicap can be a hateful burden. The situation also can be hard for other children. Psychologically and socially, the situation may place unbearable restrictions on the family; care is a 24-hour responsibility every day of the year, requiring a tremendous amount of energy and emotional involvement. The care of the child may result in financial problems. The homemaker-home health aide helps the family understand the child's limitations and capabilities, shows them how to meet the child's physical and emotional needs. Through acceptance of all family members as individuals and by understanding their needs, the family is provided support in their efforts to adjust to the problems of caring for a retarded child.

The responsibility is normally with the parents, but in times of crisis such as illness of the mother, the responsibility may become the homemaker-home health aide's. In some instances, the task will be to relieve the mother or responsible person for shopping, errands and recreation. The family may be unable to cope with the care demands because of fatigue or limited ability. As in the care of all children, the homemaker-home health aide respects the parents' role and supports and strengthens the relationship between child and parents.

The various ways in which the homemaker-home health aide may help care for and train the mentally retarded are discussed.

The homemaker-home health aide working with the developmentally-disabled individual and the family may function in two distinct ways. The first consists of assisting and relieving the mother or responsible individual in the personal care of the individual. The second involves facilitating the treatment by assisting and teaching the family and child techniques that help the child's development.

The retarded child has the same physical and emotional needs as a normal child. Except in cases of severe mental or physical handicap, these needs can often be met at home. *See Section II, Unit B.*

Whatever form the disability takes, and whatever treatment is provided, the homemaker-home health aide makes certain that the child is as tenderly cared for, as sympathetically listened and talked to, as clean and as nicely dressed, as any normal child. Therefore, the homemaker-home health aide:

- assists with personal care as required by the situation

- demonstrates techniques in activities of daily living—i.e. self-feeding, drinking from a cup, use of finger foods, toilet-training, etc., using techniques that break tasks into small units—emphasizes the need for perseverance and long-term efforts, and helps the child to acquire skills of daily living which are basic to independent and social activities and add to the quality of living;

- guards against overprotection, encourages independence, especially when families are afraid to allow the child to join others in play or to attend special classes

- encourages the individual in making the most of mental and physical capabilities and builds up the individual's concept of self

- encourages positive behavior. Behavior may be of an asocial nature which sets the child or individual apart. Differences in behavior may interfere with the child's ability to participate in the activities of children of his own age, preventing his social development. Techniques for dealing with extreme and unusual behavior include reinforcing and rewarding acceptable behavior, ignoring unacceptable behavior, and being consistent in discipline and reactions to behavior. If new behavior patterns are to be developed, this must be a step-by-step process and only as included in the plan of care. Goal-setting in which the family and individual participate is important to progress and behavior changes

- play is essential to the development of all children. The developmentally disabled child, especially, needs play which can develop motor skills and encourage social and emotional development. Play should be adapted to his physical and mental limitations so that he can experience success in the play activity. Fatigue should be avoided.

In general, the homemaker-home health aide supports, assists and encourages the family by teaching and demonstrating methods and approaches that help achieve the greatest development within the limitations imposed by the disability.

Depending upon the policies of the agency, respite care may be on a routine basis or intermittent. If relief is occasional, it is important that the homemaker-home health aide become familiar with the treatment and patterns of care used by the family and be introduced to the child or individual beforehand.

Cerebral palsy is the second type of developmental disability considered in this teaching module.

"Due to damage to the brain in earliest childhood, the development of a cerebral-palsied child is retarded or stopped and becomes disorganized and abnormal."* Characteristics of the cerebral-palsied child will vary in degree, and each one may be affected differently:

- insufficient to lack of control of the head
- inability to use arms and hands to grasp and hold things
- lack of ability to balance and control posture, especially in sitting, standing, and walking
- the spastic child is stiff; however, some may be flaccid or "floppy"
- variation in intelligence ranges from normal to sub-normal, depending upon the extent of the brain injury.

The care and handling of the cerebral-palsied child may be a factor in determining the degree of his eventual ability for self-care. Some may be too handicapped, but others respond to proper care.

A comprehensive plan of care should be based on a careful evaluation and diagnosis by professionals. Different professional therapists may be needed as the child progresses through different stages of development. These include physical, speech and occupational therapists, educational specialists, and others. The parents or caretaker should be instructed by a team member in the exercises and management to insure proper and consistent care. For example, erroneously applied exercises could hinder development rather than help.

Some specific guides for the homemaker-home health aide in the care of the cerebral-palsied individual should be emphasized.

The child should be helped to take his place in the family unit as naturally as possible and not be overprotected beyond what his condition requires.

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* Finnie, Nancie R., Handling the Young Cerebral Palsied Child at Home, E.P. Dutton & Co., Inc., New York, 1970, pp. 8-9. Foreword by Dr. K. Bobath.

Treatment should be related to all the activities of daily living, not limited to a certain period of the day. The care needs of the normal child (*Section II, Unit B*) are basic to the care of the cerebral-palsied child. Generally, the role of the homemaker-home health aide is the same as for the retarded child with certain specific considerations:

- handle slowly and give the child a chance to make an adjustment to a change in body position. Takes longer than a normal child to understand, and there is a need for constant repetition

- keep the body in normal alignment as much as possible

- encourage child's participation in dressing, choice of food, etc.

- talk to the child. When older, give child an opportunity to speak by waiting and listening

- by help and guidance, the child will learn to do more and more for himself. However, excessive effort or fatigue should be avoided

- the cerebral-palsied teenager growing to adulthood needs additional help. He needs to be able to participate in activities in groups of his own age in order to have fun and learn acceptable behavior (*Section II, B, of Manual*). The homemaker-home health aide should help the family seek normal outlets for the cerebral-palsied teenager to the extent possible, or help develop special programs using resources such as the Association for Cerebral Palsy

- the homemaker-home health aide should support the adult disabled in seeking outside contacts, independence and work. This may mean assistance in personal care and helping to adapt the living arrangements for safe independent living.

SUGGESTED REFERENCES

Curry/Peppe. Mental Retardation - Nursing Approaches to Care. St. Louis: The C.V. Mosby Company, 1978.

This is a valuable resource for the professional concerned with the mentally retarded. Some 25 authors have contributed chapters dealing with the historical background, diagnosis, concepts of normalization, habilitation plans, case-finding and prevention. Although some chapters deal with highly technical concepts, the authors have made these understandable.

Finnie, Nancie R. Handling the Young Cerebral Palsied Child at Home. New York: E.P. Dutton, Inc., 1968.

This book is designed to help parents better understand why a palsied child reacts as he does and how such understanding should be applied in the handling and care of the child to facilitate his development to the greatest degree.

U.S. Department of Health, Education and Welfare, Mdeicaid Bureau. Assessment of Resident Care in Intermediate Care Facilities for Mentally Retarded. "How to Design and Evaluate a Developmental Plan of Care," Warren Bock, 1977, pp. 122-135.

Heaton, Edythe L. Skills in Living ... Toward a Richer Tomorrow for Adults and Teenagers with Cerebral Palsy. New York: United Cerebral Palsy Association, Inc. (no date).

Describes the principles, objectives and considerations in developing group programs and activities that can meet the needs of persons with cerebral palsy. Emphasis is placed on the teenager and his need for group activities, social development and identification.

Arnold, Irene L. and Lawrence Goodman. "Homemaker Services for Families with Young Retarded Children," U.S. Department of Health, Education and Welfare publication Children, Vol. 13, No. 4, July-August 1966, pp. 149-152.

Reports the results of controlled demonstrations utilizing homemakers in carrying out casework plans; emphasizes the complex needs of retarded children and their families.

Brodsky, Rose. "Homemaker Services in a Voluntary Agency for Families with Retarded Children," Readings in Homemaker Service, 1969, pp. 46-52. National Council for Homemaker-Home Health Aide Services, Inc.

U.S. Department of Health, Education and Welfare, Office of Human Development, Developmental Disabilities Office. 16-page Pamphlet, No. (OHD) 77-29001, 1977, U.S. Government Printing Office, Washington, D.C. 20402, defining developmental disabilities and describing provisions of the Developmentally Disabled Assistance and Bill of Rights Act of 1975.

Weinrich, Ernest. "Homemaker-Home Health Aide Services for the Handicapped." New York: United Cerebral Palsy Association, Inc., 1967. National Council for Homemaker-Home Health Aide Services, Inc.

Describes three projects in which homemaker-home health aide services were used.

A Unit of Learning about Homemaker-Home Health Aide Services. New York: Council on Social Work Education and National Council for Homemaker-Home Health Aide Services, Inc., 1968.

Soyka, Patricia W. "Homemaker-Home Health Aide Services for Handicapped Children," Child Welfare, April 1976, Vol. LV, No. 4, pp. 245-246.

Widening Horizons, The Teaching Aspect of Homemaker Service - A Guide. New York: National Council for Homemaker-Home Health Aide Services, Inc., 1974.

Smith, James D. and Eugene Talsma. "Behavior Modification," Michigan Mental Health Research Bulletin, Winter 1971, Vol. 5, No. 1.

Describes study involving training homemakers in behavior modification, indicating that homemakers can be trained in behavior modification principles even though they may not have had extensive education.

Talsma, Eugene, Executive Director of Family Service Agency of Genesee County, Flint, Michigan. "The Homemaker Carries Key Role in Child Behavior Modification," presented at the National Council for Homemaker-Home Health Aide Services, Inc., Forum, May 14-16, 1970.

Describes the successful use of homemakers in behavioral changes based on treatment objectives tailored to the family situation and to each maladaptive behavior or set of behaviors.

Jacob, Walter. New Hope for The Retarded Child. Public Affairs Pamphlet No. 210A - 381 Park Avenue South, New York, N.Y. 10016, pp. 26, revised 1975.

What Everyone Should Know About Mental Retardation. A Scriptographic Booklet - Channing L. Bete & Co. Inc., Greenfield, Mass., U.S.A.

Presents facts in a graphic, easily understood manner.

ANSWERS

1. Any of the following: hydrocephalus / genetic defects / cretinism / mongolism / some drugs during
2. Slow to sit up / pull up / crawl / walk / toilet train
3. Prenatal care / care of the new-born / new-born testing
4. All could be involved.
5. Brain damage in earliest childhood.
6. Normal intelligence.
7. As listed.
8. Reinforcement / reward / ignoring unacceptable behavior
9. Aligned as much as possible / support the head.
10. Association for Cerebral Palsy / Association for Retarded Citizens / special educational classes / day-care centers
11. Physical, speech and/or occupational therapist / doctor / orthopedist

AIDS

Suggested Films

Exercise 1: Self-Feeding

Exercise 2: Case Discussions - Homemaker Role in Developmental Disabilities

Exercise 3: Field Observations

SUGGESTED FILMS

"The Cerebral Palsied Child"

"Tuesday's Child" - shows role of parents and doctor in caring for a small mentally-retarded girl. 16mm 14 min. b/w, National Association for Retarded Citizens, 2709 Avenue East, Arlington, Texas (1955).

"Mentally-Handicapped Children Growing Up" - 16mm 30 min, Association for Instructional Material, through National Association for Retarded Children, 2709 Avenue East, Arlington, Texas. Shows difference that proper care can make in the development of the retarded.

Exercise 1: Self-feeding

Development of self-feeding for a 12-year-old who accepts feedings only by a bottle and refuses solid food.

Steps might be:

- drinking from a cup
    - held by another person
    - held by himself
    - ability to pick up and put down cup
- finger food - solid food
- use of spoon.

Exercise 2: Case Discussions - Homemaker-Home Health Aide Role in Developmental Disabilities

The homemaker-home health aide works differently in the homes of the developmentally disabled. Have the class participants consider the following cases as to:

- differences in attitude of the 3 families toward the disabled child:
    - family understanding and acceptance
    - ability to manage
    - needs of the family
- differences in the needs of the children in terms of:
    - acceptance
    - training
    - socialization.

How does the homemaker-home health aide adapt skills and knowledge to the specific needs of these families?

Cases

Mrs. Sullivan sat in the office of the social worker at Homemaker Service feeling almost afraid. She wished she had sent her husband; it seemed somehow easier for him to talk about Billy. She wouldn't have come at all, but Dr. Black had told her yesterday that if she didn't get to the hospital for surgery pretty soon she was going to lose her hearing entirely. She knew she couldn't hear as well as she could last month, even, but it really frightened her when Dr. Black said that. She had to be able to hear to take care of Billy; he is such a helpless little fellow. If only her husband could get off from work for a couple of weeks while she is in the hospital she wouldn't worry so much. She didn't want a strange person taking care of Billy.

The social worker was asking about the surgery, her doctor, how long she would be in the hospital - those things were easy to answer. Now she was asking about the family, where they lived. Glen is six years old and in the first grade, and Billy is three. "Billy has an illness," she said, "a heart condition and a cleft palate." She felt a little bit easier now. The social worker seemed interested in Billy. She said that the homemaker-home health aides are especially capable of caring for children with special problems. The social worker wanted to know more about Billy. "Billy sometimes has trouble eating, has to be fed very carefully, he's just beginning to pull himself up, but he can't walk." Mrs. Sullivan couldn't quite bring herself to say that her Billy is retarded, but how relieved she felt when the social worker asked in a matter-of-fact way if he was. She didn't seem to think it was something to hide. "Our homemaker-home health aides have cared for many retarded children; in fact, they are especially interested in working with these children," the social worker said.

National Council for Homemaker Services, Inc., A Unit of Learning about Homemaker-Home Health Aide Services, page 141.

* * *

Eric, a five-year-old mongoloid, had a considerable potential for development. He was referred to the project by a children's protective agency, which had found Eric confined in a crib in his home, treated like an infant. The family, headed by a concerned but aged grandfather with an invalid wife, appeared deprived, and their lives seemed chaotic. Eric's mother was at home only one day a week; his father was permanently absent. Six other grandchildren lived in the home. Other relatives visited sporadically. The family thought that Eric was "not quite right" but were fearful that if they asked for help for him he would be taken away from them. It took the project social work supervisor three weeks to persuade the family to accept homemaker-home health aide assistance three half-days a week.

The homemaker-home health aide found Eric friendly and active. He could say only a few words, but was able to walk and run. He had to be helped to eat. He was dirty and in diapers. The house was dirty and unkempt, and there were few normal routines of daily living. The family's main concern was that Eric be toilet-trained. After gaining Eric's friendship and confidence, the homemaker-home health aide began a toilet-training routine. Eric responded to her attempts in a few weeks. When the family saw that her approach worked, they followed the same routine in the homemaker-home health aide's absence.

As the family learned to trust the homemaker-home health aide, she eliminated much of the dirt and chaos, organized chores for the other children, set regular mealtimes, and saw to it that necessary cleaning and cooking equipment was obtained. The family was encouraged to stop treating Eric like an infant. He responded by learning to feed himself, and his vocabulary increased. The casework supervisor persuaded the family to allow her to arrange for Eric to be evaluated at the local Resident Home for the Mentally Retarded. The staff there were enthusiastic about Eric's progress and expressed belief that with continued help from the homemaker-home health aide and from the professional staff be ready to go to special classes for trainable mentally retarded children to learn simple skills.

Patricia W. Soyka, Homemaker-Home Health Aide Services for Handicapped Children, Child Welfare, April 1976, Vol. LV, No. 4, pp. 245-246.

* * *

Mickey, a 12-year-old boy referred from the city school system, had suffered brain damage from anoxia at birth, had always had seizures, did not walk until he was 6. He was still taking a bottle, refused all solid food except toast, was not toilet-trained, and had no intelligible speech. His mother had been responsible for his total care all of his life and was rarely able to leave the house.

The first goal agreed upon by his mother, the supervising nurse, and the homemaker-home health aide was to teach Mickey to drink from a cup. This was a slow process in which the homemaker-home health aide established the training routine and the mother attempted to follow the pattern. After about five weeks Mickey was able to drink from a cup and set it back down on the table. His next task was to learn to finger-feed himself and to eat solid foods. This was accomplished within two weeks. Toilet training began after the homemaker-home health aide overcame the boy's strong resistance to being taken to the bathroom. After six months of patient effort by the homemaker-home health aide and mother, Mickey was able to go to the bathroom by himself and to know when he had to go.

Although this child will undoubtedly never be able to function independently, he has experienced success in learning several skills, and his mother has found some relief from the burden of his care.

Patricia W. Soyka, Homemaker-Home Health Aide Services for Handicapped Children, Child Welfare, April 1976, Vol. LV, No. 4, pp. 245, 246.

Exercise 3: Field Observation

The module on developmental disabilities can benefit by well-planned field and laboratory practice in facilities providing services for the developmentally disabled. The experiences should be carefully planned to elicit the most learning and to overcome fears and feelings the homemaker-home health aide may have about individuals with developmental disabilities.

Factors for observation might include:

- how the developmentally disabled person is like, and different from, normal children
- some characteristics and behavior differences
- an opportunity to hold and handle young handicapped children with varying kinds of characteristics
- opportunity to observe and participate in feeding and dressing the aggressive, hyperactive child
- help care for the bedfast, severely retarded, physically handicapped child
- helping with mobility and transfer of the physically handicapped child.

The homemaker-home health aide will also become familiar with community resources for the developmentally disabled by visiting facilities, including those that simulate home environments to assist individuals in self-care and family living.

The instructor should identify available facilities and assure that they can provide meaningful learning experiences.

Possible facilities are:

- special education classes for the developmentally disabled; homemaker-home health aides might assist the teacher
- day-care centers
- intermediate-care facilities for persons with developmental disabilities
- residential facilities for the mentally retarded
- cerebral palsy centers

Appendix I, continued

MODULE D: Mental Health and Mental Illness

SUGGESTED INSTRUCTOR: Psychiatrist, Mental Health Nursing Consultant, Psychiatric Social Worker, Psychiatric Nursing Consultant

INTRODUCTION

This module is designed to provide the homemaker-home health aide who has completed the basic training course with the added knowledge and skills needed to meet more effectively the support and care needs of the mentally ill or mentally handicapped individual and his family. It presupposes a continuing, close, supportive relationship with the supervisor and therapeutic team. The rapidly increasing need of community care for the mentally ill has resulted from the early discharge of large numbers of the acutely ill and the transfer of the mentally handicapped to the community for treatment and rehabilitation after long periods of institutionalization. This has increased significantly the number of individuals and families in the community that can benefit from and need homemaker-home health aide services.

There is also a growing tendency to link community mental health services with other support services in the community. Such services provide the ill individual contact with services for the community in general as well as those based in mental health centers and clinics.

The module should provide the homemaker-home health aides with added general knowledge and understanding of their own attitudes toward mental health and illness and an added understanding of behavioral manifestations, methods of communication and observation, and the unusual stress factors which may affect the family when a member has a mental illness.

EXPECTED OUTCOME

The homemaker-home health aide will be able to:

- supplement the professional services of social and health agencies in treatment and protective programs for mentally incapacitated individuals; this involves working with the care team and being able to understand and provide services that support the plan of care

- accept unusual and sudden changes in behavior and help the individual to use positive strengths

- help the discharged, long-term-care, mentally ill individual establish and maintain a suitable environment, prepare meals, shop, improve grooming, and other activities indicated in the plan of care

- provide assistance to the family by encouragement, guidance, and adjustment to unusual behavior and help to establish an orderly home environment with the routine preparation of meals, etc.

- provide respite care for families that are overburdened by the care of the mentally ill persons

- have knowledge of community resources which may be used by the mentally ill and handicapped as well as specific emergency services

- report marked changes in the individual's behavior to the supervisor, especially when a change in the plan of care may be indicated.

CONTENT

The module on mental illness will be more meaningful when based on a review of understanding human needs, growth and development and what is meant by mental health as included in the basic curriculum (see Section II, Units A, B, and D).

Mental illness includes several varieties of more or less prolonged disabilities in thinking, feeling, or acting that produce a lessened capacity for adaptation. The transition from a state of mental health to mental illness is gradual, but frequently not identified by the family. The symptoms may differ only in degree from those felt by most people—elation, anxiety, optimism, depression, for example. It may occur at any age and in all walks of life. There are emotionally disturbed children and aged persons.

Mental illness may arise from:

- physical defects, such as brain damage
- emotional problems—fear, frustration, anxiety, insecurity
- social and environmental factors
- alcohol and drug abuse.

Certain patterns of behavior may be associated with mental illness (*see Section II, Unit D*), including:

- depression
- withdrawal
- agression
- projection
- use of physical disability

Persons with mental disorder may show serious symptoms such as:*

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* Lamb, Richard, and associates. Community Survival for Long-Term Care Patients, p. 71.

- thinking disorders
- disorders of consciousness
- disorders of orientation
- disorders of perception
- disorders of memory
- unrealistic fears
- disorders of motor aspects of behavior
- extreme variations in mood
- loss of appetite
- sleeplessness.

The changes in location of the treatment of mental illness have significance for homemaker-home health aide.

Today's treatment of the mentally ill is based on the belief that the mentally ill can best be treated in their own community. In previous years much of the treatment took place in large mental hospitals, with patients confined for months and years. Now the acutely ill are hospitalized for short periods of time in a mental hospital or psychiatric units of a general hospital and discharged to continue treatment in a community mental health center or clinic or the doctor's office. Those with long-term disability are also being transferred to care services in the community. Some of them return to their own homes and others to local care facilities. Many are in residential hotels, boarding homes or apartments where support services are limited, not utilized, or unavailable.

The treatment of mental illness requires the combined efforts of a professional team as well as the cooperation of the patient and family. Depending on the individual's type and degree of illness and his special needs, the treatment team may include some or all of the following:

- psychiatrist or other physician
- psychologist
- psychiatric nurse or mental health nursing consultant or public health nurse or psychiatric social worker
- social worker
- the homemaker-home health aide's supervisor
- the homemaker-home health aide.

The homemaker-home health aide carries out whatever personal care and other duties are assigned to her and relates to the ill person consistently in line with the therapeutic plan to help facilitate the patient's recovery and ease the strain on the family. In this way, the homemaker-home health aide not only contributes significantly to the work of the therapeutic team but also becomes a part of the therapeutic process.

It has been demonstrated repeatedly that homemaker-home health aides can be effective in extending treatment into the home. As part of the team, they have been responsible for improving significantly the quality of life for people moving out into group homes, foster homes or independent living.*

One or more of the following methods may be used to treat mental illness:

- psychotherapy or psychological treatment by a mental health professional
- change in the environment
- psychotropic drugs to stabilize behavior, alone or as adjunct to other therapy
- other types of treatment, such as electric shock.

Treatment depends upon the illness. Generally, it is now felt that psychotherapy, resocialization and rehabilitation can best take place in the community, with emphasis on adaptation. Therefore, the services the ill person receives after discharge may make a marked difference in his adjustment.

All mentally ill individuals should have a therapeutic, psychiatrically oriented plan of care with clearly stated goals. As far as possible the mentally ill person should participate in setting the goals. Generally, the plan will be based on social, psychological and physical factors.

The complexity of the care and treatment requires that the plan be known and understood by the family, the homemaker-home health aide and others who may be closely involved in the care of the individual. It should indicate the role and responsibility of the family, the homemaker-home health aide and others in supporting and assisting in the treatment. The psychiatrist or therapeutic team should indicate accepted behavior, how to deal with it and the tolerance level of the mentally-ill person, so that the expectations of the family and others will be realistic and relate to the goals for the individual. If drugs are being used, the expected results and undesirable reactions should be indicated by the psychiatrist. The plan must indicate action to be taken if a crisis or emergency arises. The plan should be reviewed and revised as needed.

The homemaker-home health aide should be assured of the support and ready access of the supervisor and treatment team when working with anyone but this becomes especially important in work with the mentally ill individual and his family.

The homemaker-home health aide needs awareness of how deeply mental illness may affect the family and its relationship.

Difficult to recognize in its initial stages, harder yet to accept, mental disturbance puts the whole family under emotional strain, especially if the mother is the one who is ill. Part of the strain comes from the family's mixed emotions. There is resentment of the nature of the illness but love of the patient. Consciously or subconsciously, they feel that they are in some way to blame, yet irritated by the ill person's behavior. They are loyal to the victim, but may feel embarassment for the family. At the same time that they are concerned for the individual's welfare, they may be disturbed by a threat to their own way of life. Attitudes and reactions of the family may fluctuate, depending on mood and circumstances and sometimes on a person's age.

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*Homemaker-Home Health Aide Services to the Mentally and Emotionally Disturbed. National Council for Homemaker-Home Health Aide Services, 67 Irving Place, New York - p. 63.

- children, unable to understand what is wrong, are apt to be bewildered, apprehensive, and ashamed, even though they do not know why; they may also be physically afraid.

- adolescents under favorable conditions are a mixture of eagerness and timidity, bravado and insecurity. Mental illness in the family may set them apart from the "crowd" and often inflicts heavy responsibilities on them

- husbands and wives of the mentally ill are weighed down with anxiety about the mentally ill partner and the possibility that the illness will be long, cannot be cured, or may recur. The welfare of the children, medical expenses and loss of income create further worries.

The role of the homemaker-home health aide in mental illness is considered from the standpoint of basic activities and those specific to mental illness.

Homemaker-home health aide services differ in relation to the treatment and plan of care for the individual and the family situation. It may involve:

- basic services that a homemaker-home health aide would normally provide in households where support services are needed

- full cooperation with the treatment team working under the supervisor

- household responsibiliites, including care and maintenance of the home *(Section III, Unit A)* and planning of meals *(Section III, Unit B)*

- personal and physical care of any member of the family as may be required *(Section IV, Units C, D, E, F, and G)*

- temporary assumption in a time of crisis of the responsibilities associated with the head of the household.

Homemaker-home health aide services related specifically to the individual with mental illness and his family include:

- helping the family to understand the nature of mental illness and the progress being made on the basis of information from, and with the approval of, the supervisor or treatment team

- accepting and earning the trust of the mentally ill person including accepting unusual behavior, supporting positive behavior and listening attentively. This means accepting good and bad qualities without being judgmental. The mentally ill person wants to be accepted as himself and should be given time to become acquainted. It is better not to rush the relationship. The mentally ill person is insecure and a relationship that is consistently the same helps him feel secure

- understanding the expectations of the therapeutic plan designed for the mentally ill individual and the expected contribution of the homemaker-home health aide

- helping the family to accept and cope with unexpected and unusual behavior

- helping create a favorable climate in the family situation when the individual is treated at a mental health center or clinic while living at home

- helping in the reorientation and rehabilitation of individuals with long-term mental illness and disabilities to living in the community by working with them teaching grooming, shopping meal planning and generally helping in the redevelopment of social skills

- knowing what to do, whom to call, when an emergency happens

- reporting observation of behavior of the ill individual and existing family and environmental factors that may influence treatment

- knowing the community resources for mentally ill and disabled persons, such as

  . day treatment centers

  . sheltered workshops

  . vocational rehabilitation services

  . friendly visiting services

  . recreation department of park services

  . home delivered meals

  These should be used only if the condition of the individual permits and is approved by the treatment team. However, the homemaker-home health aide may suggest to the team that the patient may be ready for a particular community service.

Because of the complexity of working with the mentally ill, some communication skills may need strengthening.

Although the homemaker-home health aide has learned about human needs and the skills needed in working with people, some skills should be reinforced for working with the mentally ill. This includes a better understanding of:

- Communication skills, such as:
  - verbal communication, i.e., the use of simple sentences, organizing what is to be said and basing communication on facts; mentally ill persons are often suspicious, and all communication must be directed toward creating trust
  - nonverbal communication, such as body language, eye contact, gestures, etc. are especially significant in working with the mentally ill
  - listening techniques such as
    - . simple listening can be helpful to the ill individual and provide useful information for the treatment team
    - . active listening involves the use of helping phrases or suggestions, such as "It seems", "you feel", and "if I understand you"
  - assistance in behavior modification may be specified in the treatment plan; the family must be active participants. Some techniques include:
    - . reinforcement of acceptable behavior
    - . ignoring unacceptable behavior
    - . step-by-step modification of certain aspects of behavior results in the development of a new pattern or change in an old pattern
  - observation and awareness of behavior changes and factors affecting the mentally ill person. The homemaker-home health aide can make a significant contribution by careful observations of the time and place of the occurrence of behavior and reactions to medication and treatment
  - recording and reporting

    Actions and behavior should be reported, as seen, in the homemaker-home health aide's own words - in writing and verbally to the supervisor and team involved in the care of the mentally ill individual.

SELECTED REFERENCES

Aldrich, C. Knight, M.D. "Homemaker Service in Psychiatric Rehabilitation." American Journal of Psychiatry, Vol. 114, No. 11, May 1968.

This article relates primarily to the use of the homemaker when the mother is mentally ill. The homemaker-home health aide helps to stabilize the family, provides information to the supervisor and treatment team. The article describes conditions under which a homemaker-home health aide should and should not be assigned.

Doyle, Kathleen Cassidy: When Mental Illness Strikes Your Family. Public Affairs Pamphlet No. 172, p. 28. Revised 1977. 381 Park Avenue South, New York 10016.

Furst, William, M.D. and Lucille Hunt. A Primer on Mental Health Communication for Visiting Homemakers. Prepared for use of CHR-ILL Service, Visiting Homemakers, Montclair, New Jersey.

For the trainee, this booklet describes communications skills in basic understandable situations. This booklet is presently being revised and will be available for 75 cents a copy. Inquire through the National Council for Homemaker-Home Health Aide Services, Inc.

Lamb, H. Richard and Associates. Community Survival for Long-Term Patients. Jossey-Bass Publishers, San Francisco, 1976.

This book describes guiding principles and point of view regarding community treatment and rehabilitation of the long-term mentally ill patient. It considers in detail the various living arrangements and proposed ways in which such living can be more helpful to the patient. Considered are the use of day treatment centers, the therapeutic use of work and ways by which individuals may acquire more social competence.

Milt, Harry. Serious Mental Illness in Children. Public Affairs Pamphlet No. 352, p. 28, 1968. 381 Park Avenue South, New York 10016.

S[illegible]achnow, Jody and Sue Matorin. "Community Psychiatry Welcomes the Non-Professional." Reprinted from The Psychiatric Quarterly, Vol. 43, pp. 492-511, July, 1969.

Describes a project using nonprofessionals on a community psychiatric service. Nonprofessionals were used to accomplish therapeutic goals, including narrowing the gap between the hospitalized patient and family, shortening the hospital stay by providing transition to and support in the community, and reducing stress in the patient's life, thereby preventing rehospitalization.

Sieder, Violet and Charlotte J. Cardiff. Homemaker-Home Health Aide Services to the Mentally Ill and Emotionally Disturbed: A Monograph. National Council for Homemaker-Home Health Aide Services, Inc., 1976.

A report of a study sponsored by the National Council. It reports ways in which homemaker-home health aide services have proven effective to prevention, treatment and rehabilitation of the mentally ill, and considers problems relating to service delivery, administration, finance and community relations.

Smith, James and Eugene Talsma. "Behavior Modification." Michigan Mental Health Research Bulletin, Winter 1971, Vol. 15, No. 1.

Describes a study involving the training of homemakers in behavior modification, indicating that homemakers can be trained in behavior modification principles even though they may not have extensive educational backgrounds.

Talsma, Eugene, Executive Director of Family Service Agency of Genesee County, Flint, Michigan. "The Homemaker Carries Key Role in Child Behavior Modification." Presented at National Council for Homemaker-Home Health Aide Services, Inc., Forum, May 14-16, 1970.

Describes the successful use of homemakers in behavioral changes based on treatment objectives tailored to the family situation and to each maladaptive behavior or set of behaviors.

U.S. Department of Health, Education and Welfare, Health Care Financing Administration. Medical Assistance Manual, Part V: Mental Health Care in Skilled Nursing and Intermediate Care Facilities.

A discussion of the desirable care to be provided by skilled and intermediate care facilities that are institutions for mental illness under the Medical Assistance Program.

Widening Horizons, The Teaching Aspect of Homemaker Services - A Guide. National Council for Homemaker-Home Health Aide Services, Inc., New York, NY, 1974.

Thorman, George, Elizabeth Ogg. Toward Mental Health. Public Affairs Pamphlet No. 120A, September 1976, 381 Park Avenue South, New York 10016.

ASSESSMENT

1. Mental illness occurs at _____ age.
2. The team treating mental illness includes one or more professionals; check which must be involved:
   ( ) Psychiatrist ( ) Psychologist
   ( ) Social Worker ( ) Doctor
   ( ) Mental health nurse ( ) Psychiatric social worker
3. Name 3 places where the mentally ill person may receive treatment:
   1. ________________________________
   2. ________________________________
   3. ________________________________
4. Today some of the mentally ill are treated in the ________________.
5. Every mentally ill person should have a ______ plan.
6. The therapeutic treatment plan should include guidance for the family and homemaker-home health aide in at least 2 ways:
   1. ________________________________
   2. ________________________________
7. Mental illness places great stress on the family because:
   1. ________________________________
   2. ________________________________
   3. ________________________________
8. Name three ways in which the homemaker-home health aide can help the mentally ill person:
   1. ________________________________
   2. ________________________________
   3. ________________________________
9. How can the homemaker-home health aide help the family of the mentally ill mother?
   1. ________________________________
   2. ________________________________
10. When caring for the mentally ill person, report to the supervisor or treatment team any ____
    ____
11. When assigned to a mentally ill person, the homemaker-home health aide needs frequent contact with:
    1. ________________________________
    2. ________________________________
12. Name two community agencies that could be used by the mentally ill person:
    1. ________________________________
    2. ________________________________

ANSWERS

1. Any age
2. All could be involved.
3. Any of these:
    - mental hospital
    - psychiatric unit of a hospital
    - mental health center
    - clinic
    - doctor's office
    - stays at home
4. Community
5. Treatment plan, psychiatrically oriented
6. Expected behavior
   Limitation on the ill person's ability
7. Guilt
   Financial problems
   Welfare of children
   Worry over individual's illness
8. Accepting and earning his trust
   Listening
   Assisting by observation
   Supporting behavior according to treatment plan
9. Maintaining the home
   Caring for the children
   Preparing food
10. Changes in behavior
    Family problems
    (Could be a number of right answers)
11. Supervisor
    Treatment team
12. Day-care centers
    Sheltered workshops
    Day treatment centers
    Mental health centers

AIDS

Suggested Films

Exercise 1: Cases for Discussion of the Homemaker-Home Health Aide's Role in Mental Illness

Exercise 2: Field Observations in Mental Health Services

Exercise 3: Communication Skills

SUGGESTED FILMS

"Bold New Approach", 62 min., black and white 16 mm
presents the concept of the comprehensive
community mental health center.
Mental Health Film Board, 8 East 93rd Street,
New York, New York 10028

"Home Fires", National Council for Homemaker-Home
Health Aide Services, Inc., 67 Irving Place,
New York, New York 10003

Also, contact the local mental health center and State Department of Health for the loan of films.

Exercise 1: Cases for Discussion of the Homemaker-Home Health Aide's Role in Mental Illness

The role of the homemaker-home health aide will respond to the needs of the individual and family and to the plan of care that has been developed by the professional team. In the following cases, identify:

- signs and behavior that the homemaker-home health aide might observe
- what should be reported to the supervisor
- how did the homemaker-home health aide help change the behavior of Mrs. Keen
- how do communication problems with Mrs. Keen and Mrs. Ferguson differ
- how are the needs of the children in the Ferguson and Peabody families alike - how different
- how did the role of the homemaker-home health aide differ in each case

In addition to possessing the general characteristics as outlined in the job description -- "maturity, good judgment, sensitivity, patience and skill in human relationships," the homemaker-home health aide who works with the mentally ill must be resourceful and especially receptive. D.H.R.S homemaker-home health aides observed in District III displayed a degree of personal caring which was contagiously transmitted to those being served, many of whom could again begin to care about and for themselves.

Mrs. Keen, a small-town gentlewoman in her 60's, was referred for homemaker service from a general hospital following an acute illness; she was malnourished and unable to take care of herself. She had managed to isolate herself and had become the concern of neighbors and police by her peculiar behavior and paranoid accusations. The preceding summer she had wandered the streets in heavy clothing and in the coldest weather was going abroad without wraps. Frequently she had called police, accusing a visitor of walking off with her possessions.

The homemaker-home health aide, met with suspicious silence, arranged for dinner to be delivered from Meals on Wheels, went in at noontime each day to see that she ate, took her medication, and was physically clean and comfortable. Within a short time the vital young worker had taken her out on shopping trips for food and clothing, helped her prepare a dish for the evening meal and bring some order into the old family residence with its Victorian furnishings and decor. Part of the house had been made into two apartments from which there was rental income, but she had cut off any contact with tenants. Disoriented as to time, she lived in the past, waiting for her father to return from work and told glamourous tales of her youth and beauty. To please the homemaker-home health aide she began to take an interest in her appearance, dressed attractively and was gaining weight.

Still to be learned were facts about her history and relatives. The agency program administrator, homemaker-home health aide supervisor, along with the homemaker-home health aide, after legal and medical consultation, planned to recommend to her the type of care which seems best suited to her situation.*

* * *

Mrs. Hanson, homemaker-home health aide, reports that Mrs. Ferguson seems worse again. She is vomiting almost daily and had dizzy spells. Sometimes Mrs. Ferguson just sits staring into space and does not respond to the children or to Mrs. Hanson. Her physical appearance is one of exhaustion, although she dresses neatly every morning. When Mrs. Hanson arrives in the morning she immediately makes coffee and tries to sit down at the table and talk with Mrs. Ferguson for a few minutes. Often then she is able to get some verbal response from her, but when Mrs. Hanson gets busy with the housework and the three pre-schoolers (after the four other children have gone to school) Mrs. Ferguson seems to "get one of her spells." Mrs. Hanson is quite puzzled that the hospital released Mrs. Ferguson when she is still so depressed. As far as she can tell the children do not seem to be upset when their mother does not respond to them. Mrs. Hanson is at a loss as to what would help Mrs. Ferguson at this time. She hates to leave the house at six o'clock knowing that Mr. Fergson will not be home for at least another hour.**

* * *

When the mother of three small children required sanitarium care for a depression, the psychiatrist recommended homemaker-home health aide care. Mr. Peabody, the father, a well-to-do executive, could easily have hired a housekeeper through an employment agency. He recognized, however, that a homemaker-home health aide was better for the children that a housekeeper who did not have the advantages of contact with casework services, or than a somewhat controlling grandmother whose presence in the house would have been a serious threat to the mother. After a few weeks, the mother returned from the hospital, then relapsed, and later came home again. Meanwhile, the homemaker-home health aide, bulwarked by the agency, gave consistent support both to the father and to the children through the periods of transition. She made it possible for the rest of the family to give security to each other during the mother's illness, and for the mother to return to a familiar and organized environment during her remissions.***

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*Sieder, Violet; Charlotte Califf, Homemaker-Home Health Aide Services to the Mentally Ill and Emotionally Disturbed. National Council for Homemaker-Home Health Aide Services, 67 Irving Place, New York, NY 10003, p. 68.

**Council on Social Case Work, National Council for Homemaker-Home Health Aide Services -- Teacher's Source Book, p. 131.

***Ibid, pp. 91-92.

Exercise 2: Field Observations in Mental Health Services

Working with the staff of the mental health facility provides an opportunity for the homemaker-home health aide to observe behavior and how it differs from or is an intensification of normal behavior. It provides an opportunity to observe how nurses and homemaker-home health aides relate to the mentally ill individuals and an opportunity to observe disorders of orientation, thinking, etc. The observation may also help the homemaker-home health aide clarify feelings and attitudes toward mental illness.

The use of field observations for learning purposes requires preliminary assessment of the facility to determine usefulness as a teaching resource and planning with personnel for the experience so that they understand the expected outcomes and the kind of experiences that the homemaker-home health aide needs to be able to function effectively in the home, i.e.,

- how to relate to a mentally ill person
- how behavior can be met
- treatments.

Suggested places for field observations:

- psychiatric unit of a hospital
- mental health center
- mental health clinic
- sitting in on a team meeting in which homemaker-home health aide service is involved.

Exercise 3: Communication Skills

Using the cases in Exercise 1, have one person assume the role of the homemaker-home health aide and another the role of Mrs. Keen, using communication techniques:

- listening - simple and active
- body language
- verbal
- eye contact.

APPENDIX II

BASIC NATIONAL STANDARDS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES

I. The agency shall have legal authorization to operate.

This standard protects the community by specifying that the service must be provided by an agency which has a legal right to operate and is accountable to the community.

II. There shall be an appropriate, duly constituted authority in which ultimate responsibility and accountability are lodged.

This standard further protects the community and people served by assuring that there will be a group of people who take responsibility for the agency's work.

III. There shall be no discriminatory practices based on race, color or national origin; and the agency either must have or be working toward an integrated board, advisory committee, homemaker-home health aide services staff and clientele.

This standard reflects the American commitment to equal opportunity for all citizens. The standard applies equally to those who provide homemaker-home health aide services (board and staff) and to those who receive them.

IV. There shall be designated responsibility for the planning and provision of financial support to maintain at least the current level of support on a continuing basis.

Adequate funds are needed to meet the needs of the people in the community; it is important that the staff of the agency be paid adequately and that there are sufficient funds to provide a quality service with well-trained, responsible personnel.

V. The service shall have written personnel policies; a wage scale shall be established for each job category.

While this standard might seem to be a protection only for the agency staff members, it is also a protection for the community and for those who are served by the agency. Good personnel policies will attract and keep good staff members. The measure of a good service is the caliber of the agency's staff.

VI. There shall be a written job description for each job category for all staff and volunteer positions which are part of the service.

Job descriptions are the guides developed to recruit qualified staff and to describe various roles and functions needed by an agency to fulfill its mission. A good job description will require responsibilities for a particular position that are in keeping with the educational and experience qualifications called for.

VII. Every individual and/or family served shall be provided with these two essential components of the service:

- Service of a homemaker-home health aide and supervisor
- Service of a professional person responsible for assessment and implementation of a plan of care

This standard represents the "heart" of homemaker-home health aide service. It is the key standard - the key to quality service. Homemaker-home health aide service is a team service which includes both the professional and the homemaker-home health aide personnel in an agency. This standard protects those served by assuring them of a competent team which will provide service according to a professional plan. It protects the aide by assuring that there will be a well-defined plan within which to work. It protects the professional team by providing for a well-trained and supervised paraprofessional worker who knows how to be sensitive to changes and to share observations of conditions which affect the care plan.

VIII. There shall be an appropriate process utilized in the selection of homemaker-home health aides.

It means that the agency should reach out in many ways into all sections of the community to attract competent people. It means that homemaker-home health aides should be selected for their maturity, stability and capacity to work with many different people in different situations, rather than according to some other kinds of criteria such as number of years of schooling.

IX. There shall be: a) initial generic training for homemaker-home health aides such as is outlined in the National Council for Homemaker-Home Health Aide Services' training manual; b) an ongoing in-service training program for homemaker-home health aides.

"Generic" training can be explained as including preparation of the homemaker-home health aide to work in situations requiring insight and the application of psychological principles where there is a social or emotional problem and preparation to assist in personal care and rehabilitation of the sick or disabled.

X. There shall be a written statement of eligibility criteria for the service.

This standard provides an essential safeguard for the individual or family who applies for service. It assures that acceptance for or denial of service is based on well-defined reasons and is not a matter of some one individual judgment. Agencies are encouraged in the application of this standard to help those who are not eligible for homemaker-home health aide service to find appropriate service elsewhere in the community.

XI. The service, as an integral part of the community's health and welfare delivery system, shall work toward assuming an active role in an ongoing assessment of community needs and in planning to meet those needs, including making appropriate adaptations in the service.

This standard helps the community by making the agency conscious of its role as a vital part of its human services and therefore responsible for working with others in the community to improve services.

XII. There shall be an ongoing agency program of interpreting the service to the public, both lay and professional.

Making sure that the general public and professional people in the community know about homemaker-home health aide services helps people know where to turn when they or someone they know is in need of home care.

XIII. The governing authority shall evaluate through regular systematic review all aspects of its organization and activities in relation to the service's purpose(s) and to community needs.

Annual reviews and periodic in-depth self-studies of the agency's service are required by this standard so that the program's effectiveness and efficiency can be evaluated and strengthened. The accreditation program of the National Council for Homemaker-Home Health Aide Services, Inc., calls for broad participation of all groups and specifies that the board, committees, all levels of staff, including the homemaker home health aides, and persons receiving service, should be included in the analysis of the service so that all interests are protected and served.

XIV. Reports shall be made to the community and to the National Council for Homemaker-Home Health Aide Services as requested.

Community relations and public accountability are important to an agency. Public confidence must be won. People will not use nor help support a service that they do not trust.

Interpretation of Standards for Homemaker-Home Health Aide Services: 14 Standards Basic to Safe and Efficient Service, National Council for Homemaker-Home Health Aide Services, Inc., New York, New York, 1976, 9 pp.

APPENDIX III

North Seattle Community College Health/Medical Division

COURSE OUTLINE

Division: Health/Medical

Curriculum: Homemaker-Home Health Aide

Course Title: Practicum

Course Number: AHE 088

Quarter-Hour Credits: 1 to 3 (variable)

Type of Course: Occupational Preparatory

Course Description: This course is designed to supplement the Home Health Care course as practical or field experience to meet the general training needs of the homemaker-home health aide so that in order that the aide may safely and adequately perform basic nursing skills and provide home care for the ill, elderly, and/or disabled patient in their own home.

Course Objectives: The student will:

1. Plan for visits.
2. Establish a relationship with the patient and/or family served.
3. Carry out plan of care as directed by the registered nurse.
4. Report or record significant and meaningful information to the nurse or other professional team members.
5. Review and discuss home visits with field staff member immediately after experience and at set intervals.
6. Know what procedure to follow if an emergency arises.
7. Identify unmet needs of the patient and know the procedure to follow in alerting professional team members.
8. Demonstrate what has been learned in the classroom and skills in the laboratory and be provided with additional learning experience.

Class Size: 20.

Length of Course: 20 to 60 hours (varies with student needs)

References: Nursing Skills for Allied Health Services, Wood and Rambo
Other home health aide printed material
Advisory Committee recommendations

Outline Developed by: Edora Hansen, RN, BSN, PHN, November 1978.

Note: Training at North Seattle Community College was organized on a unit or minicourse basis. A Practicum or Field Experience Committee, of the Advisory Committee, set up guidelines and objectives for the practicum experience.

APPENDIX IV: Sample Agreement for Field Practice

Developed by Eleanor Van Harn
Kent County Red Cross
Grand Rapids, Michigan

This Agreement made the_____________day of______________19___

between

Community Health Service . . . . . referred to as "Agency"

and

Kent County Red Cross

That for and in consideration of the mutual promises herein contained, it is understood and agreed by the parties that:

ARTICLE I: PURPOSE

To provide home health agency clinical observation on a planned basis for selected Home Health Aide Trainees of the Red Cross.

ARTICLE II: MUTUAL RESPONSIBILITIES

A. Maintain cooperative relationship between Agency and Red Cross personnel.

B. Plan and implement patient care observations while sustaining the Agency's ultimate responsibility for quality of care, safety, rights of the patient, and be coordinated with the Agency's patient service schedule.

C. Provide current knowledge of the services and program prior to the start of the clinical observation in the Agency.

D. Contracting parties may publish the name of either Agency or Red Cross, as appropriate, in their bulletins or other public relations material.

E. Both parties will comply with the Civil Rights Act of 1964, as amended, that no person shall, on the grounds of race, color, religion or national origin be excluded from participation or denied benefits of any program or activity.

F. The clinical experience will include home visits with Agency Aides to observe and assist with tasks designated by the Registered Nurse on the Home Health Aide Assignment Sheet.

ARTICLE III: RESPONSIBILITIES OF RED CROSS

A. A Red Cross Educator assigned to the Agency will establish a plan for implementation of the trainee observation in conjunction with an assigned Agency Representative at least two (2) weeks prior to the clinical experience.

B. Theoretical content of home care service shall be taught to the trainee, in advance of the clinical observation.

C. A qualified Educator, on the basis of one per every group of fifteen (15) or less trainees, shall be responsible for trainee instruction and supervision during the clinical observation and/or experience. The qualified Educator must provide the Agency with evidence of adequate competence in community health nursing.

D. The Red Cross Educator and trainees will observe Agency policies and regulations. Nonadherence to policies may result in a withdrawal of clinical observation either for the individual concerned or for Red Cross.

E. The Red Cross Educator will assume ultimate responsibility for the trainee's education given and the completion of any service documents.

F. The Red Cross will indemnify, and hold harmless, the Agency from and against any and all losses, detriments, damages, expenses, judgements, by reason of any misfeasance on behalf of the Educator in the performance of activities under this Agreement, provided that the Agency gives the Red Cross due and timely notice of any claim or pendency of suit and reasonably cooperates with the Red Cross in investigation and defense.

G. The Red Cross will be responsible for providing a written letter of agreement to be signed by the sponsoring agency and the trainee. The sponsoring agency and trainee will indemnify, and hold harmless, the Agency from and against any and all losses, detriments, damages, expenses, and judgements by reason of any misfeasance on behalf of the trainee in the performance of activities under this Agreement, provided that the Agency gives the sponsoring agency due and timely notice of any claim or pendency of suit and reasonably cooperates with the sponsoring agency in investigation and defense.

ARTICLE IV: RESPONSIBILITIES OF AGENCY

A. An Agency Representative to serve as trainee and Red Cross liaison will be designated. The Agency Representative will review all selected trainee clinical observations to coordinate with the Agency's patient and service schedule.

B. A general and specific orientation of Educator to the Agency's objectives, policies and programs will be provided.

C. Space for Educator, trainee previsit and postvisit conferences will be provided.

D. Books, publications and other reference materials may be used, on Agency premises by Educator and trainees.

ARTICLE V: GENERAL CONDITIONS

A. The parties agree that patient information and private information about the Agency acquired by the Educator and trainees is confidential and may not be disclosed to anyone.

B. It is understood and agreed that trainees are not Agency or Red Cross employees. After completion of training program any responsibility of the Red Cross shall terminate with regard to such trainees.

C. Transportation to and from the Agency, as well as to homes, is the responsibility of the individual trainee.

D. Health Care is the individual trainee's responsibility and will be at the expense of the individual trainee. Community emergency facilities will be used in case of accident or sudden illness.

ARTICLE VI: TERM OF CONTRACT, RENEWAL AND TERMINATION

A. This Agreement shall be effective from January 1, 1979, through December 31, 1979. It shall remain in force during review and renegotiation.

B. This Agreement may be modified or amended by mutual consent of the parties.

C. This contract may be terminated in part or whole on written notice by either party of its intention to do so, at least sixty (60) days in advance at the end of any month.

D. Failure to comply with the conditions, agreement and terms of this contract may be interpreted as cause for immediate termination of this contract.

It is understood that this is the entire contract between Community Health Service, Inc., and the Kent County Chapter of the American Red Cross.

In witness whereof, this Agreement has been duly executed and the individual(s) or officer(s) signing in behalf of the Kent County Red Cross and Community Health Service, Inc., certifies by their signature that they are authorized to sign this Agreement on behalf of their respective agencies and that all terms of the Agreement will be appropriately adhered to.

KENT COUNTY RED CROSS ______________________________
Name Title Date

COMMUNITY HEALTH SERVICE ______________________________
Name Title Date

APPENDIX V:

HOMEMAKER-HOME HEALTH AIDE PRACTICUM - DOCUMENTATION OF EXPERIENCE
WORKSHOP III - PERSONAL CARE

NAME: DATE: SUPERVISED BY:

	WHERE OBSERVED			DEGREE OF COMPETENCY				
KNOWLEDGE AND PRACTICAL SKILLS	in field	not obs'd	in class	very good	good	avg.	fair	poor
1. Recognizes signs and symptoms of illness								
2. Reports and records signs and symptoms of illness according to agency procedures								
3. Takes temperature, pulse, and respiration								
4. Uses procedures which prevent the spread of infection when providing personal care								
5. Assists in personal hygiene and grooming, including: A. Bed bath								
B. Sponge, tub, or shower bath								
C. Shampoo, sink, tub, or bed								
D. Nail and skin care								
E. Oral hygiene								
6. Makes occupied beds, improvising when necessary								
7. Performs tasks using good body mechanics								
8. Assists person in ambulation								
9. Positions person in bed								

continued:

Appendix V continued:

NAME: DATE: SUPERVISED BY:

	WHERE OBSERVED			DEGREE OF COMPETENCY				
KNOWLEDGE AND PRACTICAL SKILLS	in field	not obs'd	in class	very good	good	avg.	fair	poor
10. Eliminates safety hazards in the environment								
11. Reports on observed use of medications								
12. Stores medications correctly								
13. Assists in range of motion exercises								
14. Applies and changes nonsterile dressings								
15. Weighs a person								
16. Applies ace bandages								
17. Administers basic first aid								
18. Applies moist and dry, hot and cold treatments								
19. Provides basic ostomy care								

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